

## Chapter 7

# PSYCHIATRIC TREATMENT AUTHORIZATION AND REFUSAL

### I. INTRODUCTION

Once a person is admitted to a psychiatric facility as an involuntary patient, how is treatment authorized and what happens if treatment is delayed or refused?

The challenges around this fundamental issue are eloquently captured by the Right Honourable Beverley McLachlin, Chief Justice of the Supreme Court of Canada, in a speech she gave in February 2005:

Once again, the competing values of autonomy, treatment and protection are at play and the law in different provinces has adopted distinct approaches to deal with these issues. Forced treatment of a capable patient raises serious concerns with respect to liberty, physical integrity and equality. As the majority noted in *Starson*, “The right to refuse unwanted medical treatment is fundamental to a person’s dignity and autonomy”.<sup>1</sup> Similarly, in *Fleming v. Reid*, Justice Robins of the Ontario Court of Appeal wrote that “Few medical procedures can be more intrusive than the forcible injection of powerful mind-altering drugs”.<sup>2</sup> In the case of a mentally ill person who understands all relevant treatment information, as well as the benefits and risks of treatment, yet nevertheless refuses to consent, the interference with autonomy is great indeed.

On the other hand stands the argument that not treating severely mentally ill persons on account of their refusal to consent represents a particularly impoverished understanding of their rights and civil liberties. It assumes that the “formal” autonomy rights of persons whose will and understanding are seriously impaired by illness should be preferred to their substantive freedom and to other fundamental rights and freedoms that continued mental illness denies them. Failure to treat may well result in permanent impairment of their right to be free from physical detention and their right to have a mind free from debilitating delusions, terrifying hallucinations and irrational thoughts. Although respecting a mentally ill person’s decision to refuse treatment formally accords them equal treatment with non-mentally ill patients, abandoning such people to the torments of their illness, mental and physical deterioration, substance abuse and perhaps suicide surely does not respect their inherent dignity as human beings the argument concludes.<sup>3</sup>

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<sup>1</sup> *Starson v. Swayze*, [2003] S.C.J. No. 33, [2003] 1 S.C.R. 722 at para. 75 (S.C.C.).

<sup>2</sup> *Fleming v. Reid*, [1991] O.J. No. 1083, 4 O.R. (3d) 74 at 88 (Ont. C.A.).

<sup>3</sup> Remarks of the Right Honourable Beverley McLachlin, P.C., Chief Justice of Canada, “Medicine and the Law: The Challenge of Mental Illness” 2004, Honourable Mr. Justice Michael O’Byrne/AHFMR Lecture on Law, Medicine and Ethics, University of Alberta and University of Calgary, February 17 and 18, 2005 online:< [http://www.scc-csc.gc.ca/aboutcourt/judges/speeches/medecine\\_law\\_e.asp](http://www.scc-csc.gc.ca/aboutcourt/judges/speeches/medecine_law_e.asp)>.

The competing values of autonomy, treatment and protection give rise to major questions addressed in this chapter. The supplementary questions include: can a capable patient's treatment refusal be overridden? if the patient is not capable of consenting, who authorizes treatment? how is capability defined? what criteria or guidelines does the substitute decision-maker use in deciding to consent to the treatment or refuse it? is a substitute decision-maker bound by the capable previously expressed wishes of a person who is now not capable? how are previously expressed wishes evidenced? what happens when the delay or refusal of treatment leads to significant suffering, prolonged periods of seclusion, repeated use of mechanical restraints or lengthy periods of detention in hospital? what are the effects on other patients and nurses and other staff of untreated patients' behaviour? and what are the Charter implications of these questions and the legislative options for addressing them?

This chapter addresses these questions by providing a brief historical analysis on the separation of the authority to admit from the authority to treat. A fictional case is described illustrating the procedures and criteria used for authorizing and reviewing treatment, and against which the differences between the various jurisdictions can be analyzed. The two major procedural models for authorizing treatment used in Canada — the state model and the private model — are described and compared. The three different types of criteria used to guide a decision-maker are contrasted. These are best interests, capable wishes and modified best-interests. Provisions whereby a patient, or someone on their behalf, requests a review or appeals decisions that stop treatment are described.

The analytic part of the chapter commences with the case, *Fleming v. Reid*.<sup>4</sup> The rest of the chapter responds to a challenge raised by the court by trying to show that the involuntary treatment of involuntarily detained psychiatric patients can be justified under the Charter. The Charter implications of treatment delay and refusal are examined, as well as the various harms which can happen to patients, staff, families and society because of legislation that allows the refusal of treatment necessary to restore the patient's freedom of thought and liberty (from involuntary detention) are explored. The chapter briefly addresses other rights issues although these are discussed in more detail in Chapter 9. Consent for "special treatments" such as ECT will be discussed briefly, since some Acts have special provisions in this respect. Compulsory psychiatric treatment authorization under the *Criminal Code* is briefly mentioned.

## II. HISTORICAL DEVELOPMENT

Prior to the 1960s, the issue of treatment refusal for involuntary psychiatric patients did not arise. Authority to treat was automatically part-and-parcel of the authority to admit. Since the purpose of admission was treatment, the question of not treating did not arise. In addition, there was a general belief that if the person was not able or willing to accept hospitalization voluntarily, the person was not capable of consenting to treatment or refusing to give consent.

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<sup>4</sup> [1991] O.J. No. 1083, 4 O.R. (3d) 74 (Ont. C.A.).

The separation of the authorization for admission from the authorization for treatment, which has occurred in most, but not all, Canadian jurisdictions, occurred because of two historical developments: the rise of the bodily harm involuntary admission criterion and changes in general consent to treatment laws. Historically, in Canada and in U.S. states, when involuntary admission was based on “need for treatment”, treatment logically followed from the authority to admit against a person’s will. However, when some laws changed, initially in the U.S., to admit people with a mental disorder only if they were likely to cause “serious bodily harm”, this could be dealt with by detention alone. There was, therefore, no logical need for treatment. Indeed, some patients admitted under this criterion were not treatable. Thus, the treatment authorization process became divorced from the admission process, in the “bodily harm” jurisdictions, and in others as well.

The other historical influence that reinforced the separation of admission from treatment authority arose from general medical consent law development. A foundation of consent law is expressed in the dictum of Cardozo J. in 1914:

Every human being of adult years *and sound mind* has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.<sup>5</sup>

It should be noted that people of unsound mind were not included. Someone on their behalf has to make the decision and therein lies the policy challenge — who makes the decision and what criteria shall be used to make that decision, the patient’s best interests or the patient’s wishes? As the Chief Justice of the Supreme Court of Canada noted in her 2005 speech:

Clearly, autonomy is of fundamental importance. However, implicit in Justice Cardozo’s dictum is the fact that autonomy can never be absolute. The law governing involuntary hospitalization and involuntary treatment must balance the autonomy of the patient against conflicting concerns in a way that is respectful of the dignity and needs of mentally ill people.<sup>6</sup>

Over time, the idea has been accepted that one may be incapable in some areas of decision-making (*i.e.*, hospitalization) but capable in others (*i.e.*, to accept or not psychiatric medications). In addition, Ontario courts have determined that previously expressed competent wishes are as valid as a current consent for acceptance or rejection of treatment, in voluntary treatment situations. Capable wishes apparently must be respected no matter what the consequences, including death, for patients in a voluntary hospitalization

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<sup>5</sup> *Schloendorff v. Society of New York Hospital*, 105 N.E. 92 at 93 (N.Y. 1914) (emphasis added).

<sup>6</sup> Remarks of the Right Honourable Beverley McLachlin, P.C., Chief Justice of Canada, “Medicine and the Law: The Challenge of Mental Illness” 2004, Honourable Mr. Justice Michael O’Byrne/AHFMR Lecture on Law, Medicine and Ethics, University of Alberta and University of Calgary, February 17 and 18, 2005 online: <[http://www.scc-csc.gc.ca/aboutcourt/judges/speeches/medecine\\_law\\_e.asp](http://www.scc-csc.gc.ca/aboutcourt/judges/speeches/medecine_law_e.asp)>.

situation.<sup>7</sup> The argument has been made that the same consent rules should apply to involuntarily detained psychiatric patients.

### III. CANADIAN TREATMENT AUTHORIZATION MODELS: STATE AND PRIVATE

In all democratic countries, it is the state that mandates decision-makers to authorize involuntary admission to a psychiatric facility under mental health legislation. In all Canadian jurisdictions, there is a framework that allows admission to be authorized by someone mandated by the state. The admission is made without the consent of the person or anyone else. Previously expressed competent wishes not to be admitted are ignored. The apparent exception is in Ontario where an incapable person who meets the deterioration criterion may be admitted only if a private substitute decision-maker agrees. Once the person is involuntarily admitted, two models for the authorization of treatment are used in Canada — the “state” model and the “private” model. In a state model of treatment authorization, an independent appointee of the state (*e.g.*, hospital administrator, quasi-judicial tribunal, hospital physician or court) makes the treatment decision for incapable and, in some jurisdictions, capable patients, in the patient’s “best interests”. In a private model of treatment authorization, the state has no part. Instead, the patient if capable, or a substitute decision-maker who represents the patient if the patient is not capable, makes the decision. In the private model, if a private decision-maker is unavailable, an official specified in the legislation is the decision-maker of last resort. Depending on the jurisdiction or the circumstances, the decision-maker may be required to meet one of three possible standards: “best interests” of the patient, “capable wishes” of the patient or “modified best interests” which accepts capable wishes except where there are significant health or safety concerns. Before addressing the different ways jurisdictions handle substitute decision making where the detained person is incapable of making a treatment decision, it is important to see how they deal with detained patients who are found to be capable of making a treatment decision.

#### A. Involuntary Patient: Capable Treatment Refusal

There is no issue where a capable involuntary patient consents to the recommended treatment. Where that person does not consent, clinical, ethical and Charter issues arise. That is because the treatment being refused is the treatment they had been in need of in order to be admitted (in many provinces) and which is necessary to get them well enough to gain their freedom (in all jurisdictions). Without this treatment the person is likely to be detained indefinitely.

The different models for addressing the refusal of treatment by an involuntarily hospitalized patient who is capable of giving consent to treatment can be described as follows:

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<sup>7</sup> *Malette v. Shulman*, [1990] O.J. No. 450, 72 O.R. (2d) 417, 67 D.L.R. (4th) 321, 37 O.A.C. 281, 2 C.C.L.T. (2d) 1 (Ont. C.A.).

### 1. Capable Patients Excluded: Refusal Not Possible

There is no possibility of a capable involuntary patient refusing treatment in Saskatchewan, Nova Scotia or Newfoundland and Labrador.<sup>8</sup> This is because a person who meets all the involuntary admission criteria but is fully capable of making a treatment decision cannot be admitted involuntarily. Similarly, under the “deterioration” involuntary admission criterion in Ontario, the person must be incapable to be admitted.<sup>9</sup>

### 2. Capability Not Considered: Refusal Not Possible

British Columbia has no test of treatment capability in their Act. The involuntary admission provides authority not just for detention but also for treatment. In British Columbia treatment authorized by the director of the psychiatric unit is “deemed” to have been consented to by the patient. Even so the Regulations provide a form that allows consent by capable patients.<sup>10</sup>

### 3. Capable Patient’s Refusal Can Be Overridden

In Alberta<sup>11</sup> and the Yukon<sup>12</sup> a capable patient may refuse treatment. However, that refusal can be reviewed by the review board and overridden if the best interests test is met. In New Brunswick the tribunal can authorize treatment for a capable patient who refuses to give consent in relation to routine treatment. The tribunal uses a best interests test which includes that “it is of the opinion that, without the treatment, the person would continue to be detained as an involuntary patient with no reasonable prospect of discharge”.<sup>13</sup> In Quebec the judge can consent to treatment where a person, without justification, refuses to do so.<sup>14</sup>

### 4. Capable Patient’s Refusal Cannot Be Overridden

While the majority (eight) of the Canadian jurisdictions either do not admit capable patients involuntarily or have mechanisms that enable the provision of treatment to an involuntary capable patient, five do not (Manitoba, Ontario, Prince Edward Island, Northwest Territories and Nunavut). In these five jurisdictions, if the capable patient refuses the treatment necessary for them to be released there is no mechanism to do anything, but detain the patient untreated indefinitely. Most democratic countries do not allow involuntary patients to go untreated indefinitely. The implications of doing so will be examined later in this chapter.

<sup>8</sup> Saskatchewan: *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1, s. 24(2)(a)(ii); Nova Scotia: *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42, s. 17(e); Newfoundland and Labrador: *Mental Health Care and Treatment Act*, S.N.L. 2006, c. M-9.1, ss. 17(1)(b)(ii)(C), 28.

<sup>9</sup> *Mental Health Act*, R.S.O. 1990, c. M.7, s. 20(1.1)(e).

<sup>10</sup> See British Columbia, Ministry of Health, *Guide to the Mental Health Act*, 2005 ed. at 85.

<sup>11</sup> *Mental Health Act*, R.S.A. 2000, c. M-13, s. 29.

<sup>12</sup> *Mental Health Act*, R.S.Y. 2002, c. 150, s. 23(3).

<sup>13</sup> *Mental Health Act Services Act*, R.S.N.B. 1973, c. M-10, s. 8.11(3).

<sup>14</sup> *Civil Code of Quebec*, R.S.Q. 1991, c. 64, art. 16.

## B. Case Illustration (Fictional)

Robert Burke is 37 years old and suffering from paranoid schizophrenia. He has been involuntarily hospitalized twice when his persecutory delusions and hallucinations became acute. He responded sufficiently well to medication to be discharged but he disliked medications because of the side effects. Robert read anti-psychiatric literature voraciously including Dr. Breggin's book,<sup>15</sup> referenced by the Ontario Court of Appeal in *Fleming v. Reid*, which states that medication is ineffective and causes brain damage. He read the decision of the Ontario Court of Appeal in *Fleming v. Reid* which describes medications as "mind altering" and states that "they also carry with them significant, and often unpredictable, short-term and long-term risks of harmful side effects".<sup>16</sup> Robert also read the famous Dr. Szasz's article, "The Psychiatric Protection Order for the "Battered Mental Patient" in the prestigious British Medical Journal<sup>17</sup> advising people like him to write an advance directive to refuse all psychiatric medications under all circumstances. Robert, therefore, wrote a directive to his mother, who was his nearest relative, that under no circumstances was she to consent to have him admitted voluntarily or involuntarily to a psychiatric facility, and under no circumstances was she to authorize any type of psychiatric medications except vitamins.

Without anti-psychotic medication, Robert's psychosis became acute and he threatened serious bodily harm to a stranger. He was found to qualify for involuntarily hospitalization, and found not to be capable of making a treatment decision. Given Robert's apparent capable instruction not to be admitted and not to receive psychiatric treatment, what does his substitute decision-maker do? Assume, as another scenario, that his mother does consent to the treatment, but Robert immediately applies to the review board and then appeals the negative decision to the courts. How is this scenario handled in the different jurisdictions?

## C. State Authorization of Treatment in Patient's Best Interests

Five provinces use the state authorization of treatment model: British Columbia, Saskatchewan, Quebec, New Brunswick and Newfoundland and Labrador. Here, an appointee of the state is mandated to make the decision rather than a private individual. The standard for deciding to authorize the treatment is that the treatment is in the patient's "best interests" which would include considering the patient's wishes. Four different mechanisms for authorizing treatment can be discerned in these statutes: physician, director of the psychiatric facility, quasi-judicial tribunal and the court.

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<sup>15</sup> P. Breggin, *Psychiatric Drugs: Hazards to the Brain* (New York: Springer, 1983).

<sup>16</sup> *Fleming v. Reid*, [1991] O.J. No. 1083 at para. 27, 4 O.R. (3d) 74 (Ont. C.A.).

<sup>17</sup> T. Szasz, "The Psychiatric Protection Order for the "Battered Mental Patient" (2003) 327 British Medical Journal 1449-51.

### 1. “Best Interests” Standard

The “best interests” standard for making decisions might be thought of as simply “What is best for this person in these circumstances?” The best interests standard is used in all state models (*e.g.*, Newfoundland and Labrador) and some private models (*e.g.*, Alberta). The major contrasting standard is the “capable wishes” standard. The contrast between the standards can be shown where a person has a valid wish not to be treated and becomes an involuntary and incapable psychiatric patient. With a capable wishes standard the wishes expressed when the patient was capable must be followed and treatment refused even though it will result in suffering, danger to others and lengthy deprivation of freedom. In contrast, under the best interests standard, even though the person’s wishes are taken into account, if acceding to them would result in substantially negative consequences this could not be in the person’s best interest.

“Best interests” is not a vague concept. It is closely defined in most *Mental Health Acts* that use it. For example, in New Brunswick, in determining that the treatment is in the person’s “best interests” the tribunal shall “have regard to”:

- (a) whether or not the mental condition of the person will be or is likely to be substantially improved by routine clinical medical treatment,
- (b) whether or not the mental condition of the person will improve or is likely to improve without routine clinical medical treatment,
- (c) whether or not the anticipated benefit from the routine clinical medical treatment outweighs the risk of harm to the person, and
- (d) whether or not routine clinical medical treatment is the least restrictive and least intrusive treatment that meets the requirements of paragraphs (a), (b), and (c).<sup>18</sup>

The best interests test is widely used in legislation. The standard known as “best interests”, when used by a professional such as a physician, has been described as the “professional judgement standard”. Aboleda-Flórez and Copithorne report:

This test has emerged in recent U.S. decisions as a standard for determining how a professional should implement federal statutory and constitutional rights. The *Youngberg v. Romeo* [47 U.S. 307 (1962)] case has been interpreted to mean that constitutional rights have been satisfied if proper professional judgment has been exercised. In other words, a person has a constitutional right to treatment in conformity with competent professional judgment. ... English courts determine whether the test, described as a “best interests” test, has been met by reference to professional standards.<sup>19</sup>

The best interests test has also been found to accord with the *Canadian Charter of Rights and Freedoms*. In a Charter challenge that contended best interests are unconstitutional and should be replaced by “good faith and reasonable”, the Ontario Court of Appeal rejected the challenge and stated:

<sup>18</sup> *Mental Health Act*, R.S.N.B. 1973, c. M-10, s. 8.11(4).

<sup>19</sup> J. Arboleda-Flórez & M. Copithorne, *Mental Health Law and Practice* (Toronto: Carswell, 1994) at 5-40, 5-41.

As the material in the record demonstrates, the best interests test is widely recognized as the appropriate standard to be applied by boards, courts and tribunals who must make health care decisions for those who are unable to consent on their own. We find nothing unconstitutional about the best interests standard.<sup>20</sup>

## 2. Patient's Wishes in Best Interests Standards

Are a patient's wishes considered under a best interests standard? This is a particularly important issue if the best interests conflict with the patient's wishes (e.g., physician knows that medication is needed to treat the psychosis but the person has disagreed when capable). A number of provinces with best interests standards require the treating physician to take into account the patient's views, even if the patient is not capable of making a treatment decision. For example, in Newfoundland and Labrador, where only incapable patients are involuntarily admitted, the "best interests" criteria require the physician to consider, "(e) the wishes of the involuntary patient expressed when the involuntary patient was competent".<sup>21</sup> The assessment of best interests in Ontario, used when there are no previously expressed capable wishes, includes the consideration of "any wishes expressed by the incapable person with respect to the treatment..."<sup>22</sup> In Saskatchewan where the physician authorizes treatment on the basis of the incapable patient's best interests:

...the attending physician shall consult with the patient, explain or cause to be explained to the patient the purpose, nature and effect of proposed diagnosis or treatment and give consideration to the views the patient expresses concerning the patient's choice of therapists, the proposed diagnosis or treatment and any alternatives and the manner in which diagnoses or treatments may be provided.<sup>23</sup>

Although not all *Mental Health Acts* have an explicit requirement to take into account the patient's wishes in their best interests tests, it is contended that this is now standard medical practice, and therefore is an implicit requirement in all other Canadian *Mental Health Acts*.

Whether an involuntary patient's capable wishes are considered under best interest tests is an important legal issue since the failure to consider them led to a successful Charter challenge in Ontario in *Fleming v. Reid*.<sup>24</sup> What the Court of Appeal objected to in the Ontario *Mental Health Act* as it stood in 1991 was that the Act required the Review Board to consider only the person's best interests whereas the substitute decision-maker was bound by previously expressed wishes including treatment refusal. The Court of Appeal concluded:

...the state has not demonstrated any compelling reason for entirely eliminating this right, [that is the patient's right to have their wishes considered] without any

<sup>20</sup> *M. (A.) v. Benes*, [1999] O.J. No. 4236 at para. 40, 46 O.R. (3d) 271 (Ont. C.A.).

<sup>21</sup> Newfoundland and Labrador: *Mental Health Care and Treatment Act*, S.N.L. 2006, c. M-9.1, s. 35(2)(e).

<sup>22</sup> *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 21(2)(b)(c).

<sup>23</sup> Saskatchewan: *Mental Health Services Act*, s.s. 1984-85-86, c. M-13.1, s. 25(3).

<sup>24</sup> [1991] O.J. No. 1083, 4 O.R. (3d) 74 (Ont. C.A.).



hearing or review, in order to further the best interests of involuntary incompetent patients in contravention of their competent wishes.<sup>25</sup>

While the Ontario case is not binding outside Ontario, it is contended that in those jurisdictions that provide explicit instructions to consider previously expressed capable wishes, and in others by standard practice, that consideration serves as a “review”. The issue of the right to override treatment refusal will be considered later in this chapter.

### 3. Who Authorizes Treatment?

#### (a) *Physician Authorizes Treatment*

In Saskatchewan and Newfoundland and Labrador, it is the treating physician who authorizes treatment for involuntary patients in accordance with the patients’ best interests. To illustrate, the Newfoundland and Labrador provision, which is nearly identical to Saskatchewan, reads:

Where a person is an involuntary patient, the attending physician or other person may, taking into account the best interests of the involuntary patient, perform or prescribe diagnostic procedures that he or she considers necessary to determine the existence or nature of a mental disorder, and administer or prescribe medication or other treatment relating to the mental disorder without the consent of the involuntary patient during the period of detention.<sup>26</sup>

In Saskatchewan, the attending physician has a duty to “provide the person with care and treatment as a result of which the detention of the person in the facility will no longer be required”.<sup>27</sup> Treatment refusal would be unlikely to accord with this requirement.

#### (b) *Director of Psychiatric Facility Authorizes Treatment*

In British Columbia, if a patient is incapable or refuses to consent, the attending physician informs the director of the nature of the condition, options for treatment, the reasons for and likely benefits and risks of the treatment (Form 5), and the director makes the treatment decision. Patients are only admitted if they require psychiatric treatment and the director of the psychiatric facility has an obligation to:

... ensure (a) that each patient admitted to the designated facility is provided with professional service, care and treatment appropriate to the patient’s condition and appropriate to the function of the designated facility and, for those purposes, a director may sign consent to treatment forms for a patient detained ...<sup>28</sup>

<sup>25</sup> [1991] O.J. No. 1083, 4 O.R. (3d) 74 at 96 (Ont. C.A.).

<sup>26</sup> Saskatchewan: *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1, s. 25(2); Newfoundland and Labrador: *Mental Health Care and Treatment Act*, S.N.L. 2006, c. M-9.1, s. 35(1).

<sup>27</sup> *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1, s. 27.

<sup>28</sup> *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 8.

If the patient's wishes for treatment are not "appropriate to the patient's condition", the director could not authorize the treatment, although considering a patient's wishes is standard medical practice. Since the director must authorize treatment "appropriate to the patient's condition", this would be considered to be a "best interests" or "professional judgment standard".

**(c) Quasi-Judicial Tribunal Authorizes Treatment**

New Brunswick uses a tribunal, not a review board, to authorize routine psychiatric treatment. "Routine clinical medical treatment" is defined as "generally recognized and acceptable psychiatric treatment and other generally recognized and acceptable medical treatment that is necessary to effectively treat a mental disorder".<sup>29</sup> The tribunal can override the refusal of a capable patient and provides consent (or not) if the patient is incapable of making a treatment decision.<sup>30</sup> Relatives do not consent on the patient's behalf. The standard the tribunal uses in both cases is "best interests".<sup>31</sup>

**(d) Court Authorizes Treatment**

In Quebec, it is the court that authorizes involuntary psychiatric treatment where a legal substitute decision-maker is not approved.<sup>32</sup>

**(e) What of Robert Burke, Fictional Patient?**

In each of the jurisdictions that use a state appointed decision-maker, Robert's direction not to be treated, while being considered under the law in Saskatchewan and Newfoundland and Labrador and by practice elsewhere, could not be acted upon unless the refusal was in his best interests. In these provinces, the treatment decision is made by a state authority, not a private decision-maker, so there is no legal requirement to follow his direction to his mother. Neither is there legislation recognizing instructional advance directives (independent of substitute decision-makers) regarding psychiatric treatment within the *Mental Health Act*.<sup>33</sup>

## D. Private Treatment Authorization

In private treatment authorization jurisdictions an agent of the state (physician, director, court, *etc.*) does not make the decision. Instead, the patient if capable, or a substitute decision-maker if the patient is not capable, makes the decision. Legislation usually lists a hierarchy of substitute decision-makers including relatives. Once the decision-maker is located, he or she must be provided with information about the nature of the patient's condition and the proposed treatment, including expected positive and negative effects, in the same way a

<sup>29</sup> *Mental Health Act*, R.S.N.B. 1973, c. M-10, s. 1.

<sup>30</sup> *Mental Health Act*, R.S.N.B. 1973, c. M-10, s. 8.4(2) (competent) s. 8.4(4) (incompetent).

<sup>31</sup> *Mental Health Act*, R.S.N.B. 1973, c. M-10, s. 8.11(3).

<sup>32</sup> *Certain Personality Rights Act, 1991*, C.C.Q. 1991, c. 64, art. 16.

<sup>33</sup> See section V on Advance Directives, below in this chapter.

competent patient would be. The decision-maker agrees to the treatment plan or rejects it based on the standard in the *Mental Health Act*. Three standards can be distinguished: best interests, capable wishes and modified best interests. The method of appointing substitute decision-makers and the criteria they must use are discussed below in more detail.

### 1. Hierarchy of Substitute Decision-Makers

In order to instruct the treating physician of a patient who is incapable of making a treatment decision, on how to select a substitute decision-maker, most private authorization model jurisdictions provide a list containing a hierarchy of people who must be approached in the order provided by the list to see if they are qualified and wish to become the substitute decision-maker. The physician must approach the person at the top of the list. If that person is qualified to be a substitute decision-maker, agrees to be the decision-maker and consents to the proposed treatment, treatment proceeds. If the person does not consent, no treatment can be given. If the person declines to be a decision-maker or cannot be located, the next person on the list is contacted, and so on, until a decision-maker is found. It is not permitted to “shop” for the most favourable decision-maker on the list — if one person consents or refuses, the process stops.

The hierarchy set out in the Ontario *Health Care Consent Act, 1996* that is used by the Ontario *Mental Health Act* is similar, though not identical, to that of other jurisdictions:<sup>34</sup> guardian of the person with authority to give consent; attorney for personal care with authority to give consent; representative requested by the person and appointed by the review board to consent; spouse or partner; child or parent (or child’s guardian) entitled to consent; parent who only has right of access; brother or sister; any other relative; and the public trustee if no other qualified person can be found.

In order to become a substitute decision-maker in Ontario, a person must be capable with respect to the treatment decision, at least 16 years of age (unless he or she is the patient’s parent), not prohibited by the court or a separation agreement, available and willing to assume that responsibility.<sup>35</sup> In a number of jurisdictions with similar legislation, the person must also have had personal contact with the patient in the last 12 months (*e.g.*, Alberta)<sup>36</sup>. Although most jurisdictions use a public official (*e.g.*, public trustee/guardian) as the decision-maker of last resort, in the Yukon Territory the duty falls to the review board and in the Northwest Territories and Nunavut, to the court.<sup>37</sup>

Prince Edward Island uses a private authorization model but does not have a rigid hierarchy of decision-makers. Instead, Prince Edward Island has what is

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<sup>34</sup> *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 20.

<sup>35</sup> *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 20(2).

<sup>36</sup> *Mental Health Act*, R.S.A. 2000, c. M-13, s. 28(2)(a).

<sup>37</sup> Yukon: *Mental Health Act*, R.S.Y. 2002, c. 150, s. 21(1)(c); Northwest Territories: *Mental Health Act*, R.S.N.W.T. 1988, c. M-10, s. 19.3; Nunavut: *Mental Health Act* (Nunavut), R.S.N.W.T. 1988, c. M-10, s. 19.3.

arguably a more flexible scheme which allows the person most appropriate to be chosen. The wording is:

Where a patient is incapable and requires psychiatric or medical treatment, a substitute decision-maker, such as a guardian or a person who, in the opinion of the attending psychiatrist, is the most appropriate member of the patient's family or other person who has a close relationship with the patient, may give or refuse consent.<sup>38</sup>

Although most jurisdictions allow a person to appoint a substitute decision-maker while they are capable, prior to hospitalization, some allow a person who is incapable of consenting to treatment to have input into who the substitute decision-maker should be after being hospitalized. The Northwest Territories and Nunavut and Ontario use different mechanisms. The Northwest Territories and Nunavut state:

Where the person referred to in subsection (4) is a person described in paragraphs (1)(c) to (h) and the patient objects to that person acting as the substitute consent giver, the medical practitioner shall, giving consideration to the wishes of the patient, choose the person described in subsection (1) who is most appropriate to consent on behalf of the patient.<sup>39</sup>

In Ontario it is not the physician but the Consent and Capacity Board that deals with a request from an incapable patient for appointment of a representative chosen by the patient to give or refuse consent.<sup>40</sup> This is presumably to replace someone from the statutory list of whom the patient does not approve. The Board can also appoint someone else with the patient's permission.<sup>41</sup>

## 2. Criteria: Substitute Decision-Making

Three distinct standards or criteria for private decision-makers are identifiable in Canadian *Mental Health Acts*: "best interests", "capable wishes" and "modified best interests". The distinctions among these three criteria can be very important for patients, their treatment teams and families. In short, this is because decisions made on the standard of capable wishes can include refusal of the treatment required to relieve symptoms and effect discharge from detention. Prolonged detention because of treatment refusal would rarely be in a person's best interests and hence complete treatment refusal is unlikely under the "best interests" or "modified best interests" standard.

### (a) Best Interests

"Best interests" tests have been defined above in the section on "State Authorization of Treatment in Patient's Best Interests". Two of the private authorization jurisdictions — Alberta and Prince Edward Island — use a "best

<sup>38</sup> Prince Edward Island: *Mental Health Act*, R.S.P.E.I. 1998, c. M-6.1, s. 23(6); Northwest Territories: *Mental Health Act*, R.S.N.W.T. 1988, c. M-10, s. 19.2(5) also provides choice.

<sup>39</sup> Northwest Territories: *Mental Health Act*, R.S.N.W.T. 1988, c. M-10, s. 19.2(5); Nunavut: *Mental Health Act* (Nunavut), R.S.N.W.T. 1988, c. M-10, s. 19.2(5).

<sup>40</sup> *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 33(1).

<sup>41</sup> *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 33(7)(a).

interests” standard, as do the five state authorization jurisdictions. In Alberta the Act is silent on previously expressed capable wishes, although these may be considered by the decision-maker. Under the Act:

A person authorized by subsection (1)(a) or (c) [a substitute decision-maker] to make treatment decisions on behalf of a formal patient shall make the decisions in accordance with what the person believes to be the best interests of the patient.<sup>42</sup>

In Prince Edward Island the wording is “A substitute decision-maker or the said public official shall only consent to the treatment of an incapable patient when the substitute decision-maker or the said public official believes (a) that it is medically necessary; and (b) that its potential benefit outweighs its risks or disadvantages”.<sup>43</sup>

*(i) Reviews and Appeals*

Assume that Robert Burke, our fictional patient, because of his paranoid illness, wants to exercise every means of avoiding treatment. If he objects in Alberta, even as an incapable patient, treatment cannot be started “unless a second physician is also of the opinion that the patient is not mentally competent to make treatment decisions”.<sup>44</sup> Even then, Robert could apply to the review panel to have his incapability status reviewed. If he makes the application, the treatment stops until the review panel decision is rendered.<sup>45</sup> If the review panel rules that he should be treated, Robert can still appeal to the court and treatment cannot be started until the Court of Queen’s Bench concludes the appeal process. The decision of this court is not subject to appeal.<sup>46</sup> If the hospital or physician does not agree with a treatment refusal decision, they can appeal to the review panel. The review panel uses the same test as the decision-maker, namely “best interests”, in deciding whether or not to authorize treatment. This authority extends to overriding treatment refusals by capable patients. If Robert lived in Prince Edward Island, and either he was capable and refused treatment or his substitute decision-maker refused treatment, that refusal could be overridden by the review board. This would require the recommendation of two physicians, at least one of who was a psychiatrist that the treatment was in Robert Burke’s best interests.<sup>47</sup>

*(b) Capable Wishes*

Ontario, the Northwest Territories and Nunavut appear to be the only jurisdictions where an involuntary psychiatric patient’s capable pre-expressed wish not to be treated, that applies to the current circumstances, must be complied with irrespective of the negative consequences.

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<sup>42</sup> *Mental Health Act*, R.S.A. 2000, c. M-13, s. 28(3).

<sup>43</sup> *Mental Health Act*, R.S.P.E.I. 1988, c. M-6.1, s. 23(9).

<sup>44</sup> *Mental Health Act*, R.S.A. 2000, c. M-13, s. 28(5).

<sup>45</sup> *Mental Health Act*, R.S.A. 2000, c. M-13, s. 27(4).

<sup>46</sup> *Mental Health Act*, R.S.A. 2000, c. M-13, s. 43(5).

<sup>47</sup> *Mental Health Act*, R.S.P.E.I 1988, c. M-6.1, s. 24.

In Ontario, the mechanism for authorizing treatment has been removed from the *Mental Health Act* and rests in the *Health Care Consent Act, 1996*. The method of authorizing treatment is exactly the same whether the person is a voluntary patient (psychiatric or medical) or an involuntary psychiatric patient. If a capable involuntary patient refuses treatment, there is no mechanism to ultimately override that refusal if it is made in accordance with the Act. There are some mechanisms for reviewing the decision-making processes to ensure that the decision is made according to the legislation. Where the refusal cannot be overcome, the hospital and attending physician have no choice but to contain the patient indefinitely unless the patient recovers without treatment. If a patient is incapable, the process of selecting a substitute decision-maker has been outlined above.

The principles that govern the giving or refusal of consent by a substitute decision-maker in Ontario are:

A person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the following principles:

1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.
2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests.<sup>48</sup>

The guidelines for the assessment of "best interests" are similar to those in the New Brunswick *Mental Health Act*,<sup>49</sup> but Ontario also requires the decision-maker to take into consideration the person's values and beliefs and any incapable wishes.<sup>50</sup>

"Best interests" is the criterion used in Ontario not only when there is no known wish but also when it is "impossible to comply with the wish". What "impossible" means is not defined and does not appear to have been interpreted, in the psychiatric treatment context, by the Consent and Capacity Board or courts. "Impossible" might be viewed from a physical, practical, legal, cost, suffering, ethical or medical perspective. Manitoba and Nova Scotia which also respect capable refusals have placed limits on respecting the refusal where compliance "...would endanger the physical or mental health or the safety of the patient or another person".<sup>51</sup> Given the fact that these are involuntary patients whose chance of release without treatment are slim and whose behaviour could place other patients and staff at risk, it could be argued that this is a reasonable limit on what is possible in a humane society.

<sup>48</sup> *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 21(1).

<sup>49</sup> R.S.N.B. 1973, c. M-10, s. 8.11(3).

<sup>50</sup> *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 21(2).

<sup>51</sup> Manitoba: *Mental Health Act*, C.C.S.M c. M110, s. 28(4)(b)(ii); Nova Scotia: *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42, s. 18.

In Ontario, where best interests do not apply if there is a valid pre-expressed wish to refuse treatment, Michael Bay, former head of the Ontario Consent and Capacity Board, has stated:

The law contains almost no latitude for dealing with treatment of persons who, in the past, expressed a capable wish not to receive treatment.<sup>52</sup>

(i) *Reviews and Appeals*

In Ontario, if a capable involuntary psychiatric patient refuses treatment, the *Health Care Consent Act, 1996*<sup>53</sup> contains no provision for review or appeal. The hospital is obliged to detain the patient until he or she no longer meets the committal criteria. This could be many years or indefinitely. Similarly, in Manitoba, a capable patient who refuses treatment must be detained indefinitely and there is no appeal possible by anyone.<sup>54</sup> These provisions contrast with Alberta<sup>55</sup> where the review board can override the competent refusal, and New Brunswick where the tribunal can do so if, without treatment, there is "...no reasonable prospect of discharge".<sup>56</sup>

In Ontario, if an incapable involuntary patient has a capable previously expressed wish not to be treated or if that person's substitute decision-maker refuses treatment, the *Health Care Consent Act 1996*, provides four avenues of review. However, it is important to note that no treatment can be given until the final judicial decision is made and this can take many months or even years of involuntary detention.<sup>57</sup> In contrast in Nova Scotia treatment continues during the wait for the court unless the court specifically disallows treatment.<sup>58</sup> The avenues of review in Ontario are:

- (a) *Clarification of the wish.* The substitute decision-maker or the physician can argue that the decision-maker is not bound to refuse to consent to treatment because the wish is not clear, it is not clear that the wish is applicable to the circumstances, or it was expressed while the person was incapable. The Board can then decide the issues and give directions to the substitute decision-maker. Of course if the Board decides the wishes were clear, applicable to the circumstances and made while the person was capable, a wish to refuse treatment binds the substitute decision-maker no matter how harmful to the patient.<sup>59</sup>
- (b) *Application to depart from wishes.* Assuming that the substitute decision-maker or physician, by themselves or after clarification by the Board, decide that the wish is valid, either can still apply to the Board to override

<sup>52</sup> M. Bay, "The Ontario *Mental Health Act*" (1997) 17 *Health Law in Canada* 124 at 126.

<sup>53</sup> S.O. 1996, c. 2, Sch. A, s. 36(1).

<sup>54</sup> *Mental Health Act*, C.C.S.M., c. M110, s. 26.

<sup>55</sup> *Mental Health Act*, R.S.A. 2000, c. M-13, s. 41(1)(c).

<sup>56</sup> *Mental Health Act*, R.S.N.B. 1973, c. M-10, s. 8.11(3).

<sup>57</sup> M. Kelly, *et al.*, "Treatment Delays for Involuntary Psychiatric Patients Associated with Reviews of Treatment Capacity" (2002) 47 *Can. J. Psychiatry* 181-185; R.L. O'Reilly, "Mental Health Legislation and the Right to Appropriate Treatment" (1998) 43 *Can. J. Psychiatry* 811-15.

<sup>58</sup> *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42, s. 79(4).

<sup>59</sup> *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 35.

the wish: “The Board may give the substitute decision-maker permission to consent to the treatment despite the wish if it is satisfied that the incapable person, if capable, would probably give consent because the likely result of the treatment is significantly better than would have been anticipated in comparable circumstances at the time the wish was expressed.”<sup>60</sup>

- (c) *Substitute decision-maker did not comply with the Act.* If the substitute decision-maker refuses consent to treatment, the physician has the option to ask the board to review the manner in which the substitute decision-maker reached the decision.<sup>61</sup> Did they follow capable previously expressed wishes if known and best interests if not? The physician could present evidence, for example, that the substitute decision-maker had “manufactured” a competent wish and that, in fact, no such wish existed. In that case, the Board could order that a best interests test be applied which, presumably, would include treatment. In Robert’s case, this argument is unlikely to succeed because Robert’s mother clearly followed the principles outlined in section 21.
- (d) *Court appeal.* Given Robert’s clear capable refusal and his distrust of all medications, it is unlikely that Robert’s prior capable refusal could be overturned. However, Consent and Capacity Board decisions can be appealed to the court by the patient, substitute decision-maker, attending physician or any other party dissatisfied with the Board decision. Appeals are made to the Ontario Superior Court on a question of law or fact. The court of course, is bound by the Act. The maximum time that the parties may take to serve notice and to prepare factums is 35 days, but the court may extend the time. Also, the court must hear the appeal at the earliest date compatible with a just disposition, but there is no specified time period.<sup>62</sup> The decision of the court can be further appealed. For example, one patient appealed through the system of courts to the Supreme Court of Canada, although a hearing was not granted. During the nearly two-year period that the appeal process lasted, the patient was detained and untreated.<sup>63</sup>
- (e) *Interim court treatment order.* While the patient is waiting, detained and untreated, for the court hearing or for any appeal of the court decision, the Act does, however, allow for an interim order authorizing treatment pending the final disposition of an appeal of a Board’s decision by a court.<sup>64</sup> The grounds for the court to order treatment are the traditional “best interests” and no reference is made to the capable wishes of the patient. The only addition to the best interests test is “that the person’s condition makes it necessary to administer the treatment before the final disposition of the appeal”. While “necessary” is not further defined, it could be argued that satisfying the elements of the best interests test indicates the treatment is

<sup>60</sup> *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 36(3).

<sup>61</sup> *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 37.

<sup>62</sup> *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 80.

<sup>63</sup> R.L. O’Reilly, “Mental Health Legislation and the Right to Appropriate Treatment” (1998) 43 *Can. J. Psychiatry* 811-15.

<sup>64</sup> *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 19.



necessary, particularly for an involuntary patient who continues to be detained because of the refusal.

Applications for treatment orders are extremely rare in Ontario,<sup>65</sup> despite the fact that people may stay detained for very long periods waiting for “justice”. For example, in one study 11 people waiting for the court process had on average 253 days being detained in hospital before treatment was started. In all 11 cases, the court decision led to treatment. This is costly in terms of the patient’s health, autonomy and personal freedom, the family’s concerns and the hospital’s resources. In none of these cases, including the case of a patient who was detained for 721 days, did the hospital initiate a request for an interim treatment order, even though the test is one of “best interests” and “necessary”.<sup>66</sup>

In our case illustration, Robert’s expressed wish not to be treated would have to be honoured by his mother because his wishes can be complied with and his wishes relate exactly to the situation he envisioned, being involuntarily hospitalized in a psychiatric facility.

The substitute decision-maker for an incapable patient in the Northwest Territories must “... make decisions on behalf of the patient in accordance with the intentions the patient had before becoming mentally incompetent”, a “competent wishes” standard,<sup>67</sup> similar to Ontario. Interestingly, the substitute decision-maker is to “encourage the patient to participate, to the best of his or her abilities, in the making of decisions by the substitute consent giver on behalf of the patient”.<sup>68</sup> This mandated patient involvement is similar to that in the Saskatchewan *Mental Health Services Act*.<sup>69</sup>

### **(c) Modified Best Interests**

Manitoba and Nova Scotia use what is described here as a “modified best interest test”: the substitute decision-maker must follow capable previously expressed wishes except where that would likely result in serious harm to the person or others, when best interests must be followed. This is unlike Ontario where no matter how serious the harm to the detained person or others caused by treatment refusal, the substitute decision-maker must refuse unless it is impossible to do so. From a policy perspective this modified best interest test has the advantage of respecting competent wishes wherever possible but not allowing people to lose their freedom indefinitely and continue to have symptoms which disrupt their lives and the lives of others. In jurisdictions where the purpose of involuntary admission is treatment, this modified best interests test is consistent with that purpose.

<sup>65</sup> D. Hiltz & A. Szigeti, *A Guide to Consent and Capacity Law in Ontario, 2006 Edition* (Toronto: Butterworths, 2006) at 164.

<sup>66</sup> M. Kelly *et al.*, “Treatment Delays for Involuntary Psychiatric Patients Associated with Reviews of Treatment Capacity” (2002) 47 Can. J. Psychiatry 181-185 (personal communication R.L. O’Reilly concerning no interim treatment orders).

<sup>67</sup> N.W.T.: *Mental Health Act*, R.S.N.W.T. 1988, c. M-10, s. 19.4(7)(b).

<sup>68</sup> N.W.T.: *Mental Health Act*, R.S.N.W.T. 1988, c. M-10, s. 19.4(7)(c); Nunavut: *Mental Health Act* (Nunavut), R.S.N.W.T. 1988, c. M-10, s. 19.4(7)(c).

<sup>69</sup> S.S. 1984-85-86, c. M-13.1, s. 25(3).

In Manitoba the treatment consent decision is made “in accordance with the patient’s wishes, if the person knows that the patient expressed such wishes when apparently mentally competent”.<sup>70</sup> However, if “following the patient’s expressed wishes would endanger the physical or mental health or the safety of the patient or another person”,<sup>71</sup> the person makes the decision “in accordance with what the person believes to be the patient’s best interests”.<sup>72</sup> The best interests test is also used if the person has no knowledge of the patient’s expressed wishes. Nova Scotia has similar wording.<sup>73</sup>

*(i) Review and Appeals*

The review board in Manitoba has jurisdiction to hear argument from the attending physician where treatment has been refused, or from the patient that treatment should not have been authorized, but only for incapable patients. It must use a “best interests” test that takes into account previously expressed wishes. Where the hospital asks the review board to override a treatment refusal by a substitute decision-maker, two medical examinations must be performed. One examination must be by the attending physician and one by a psychiatrist, and both must conclude that the treatment will substantially improve the patient’s mental condition which is unlikely to improve without treatment; that the benefits outweigh the risk of harm; and that the treatment is the least intrusive and least restrictive treatment that meets the other best interests criteria.<sup>74</sup> If the review board is satisfied that these criteria are met, it may order treatment. Before it makes the order, it must “consider any wishes the patient expressed about the treatment while mentally competent, and whether or not the patient would now, given the circumstances, alter those wishes if competent to do so”.<sup>75</sup> The patient’s wishes are not determinative and, hence, this is a “modified best interests” test. If the review board orders treatment and the patient appeals to the court, treatment cannot be given until the court has heard the issue although, pending the decision, treatment without consent may be given to “prevent harm to the patient or to another person”.<sup>76</sup> In contrast with Manitoba, in Nova Scotia a review board decision can be appealed to the court (only on law, not on fact) but “the decision of the Review Board takes effect immediately unless the Court of Appeal grants a stay of any order made pursuant to this Act where, in its discretion, it deems fit”.<sup>77</sup>

If the patient is considered to be mentally capable, unlike Alberta, there is no override possible in Manitoba. The patient must stay detained indefinitely.

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<sup>70</sup> *Mental Health Act*, C.C.S.M. c. M110, s. 28(4)(a).

<sup>71</sup> *Mental Health Act*, C.C.S.M. c. M110, s. 28(4)(b)(ii).

<sup>72</sup> *Mental Health Act*, C.C.S.M. c. M110, s. 28(4)(b).

<sup>73</sup> *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42, s. 18.

<sup>74</sup> *Mental Health Act*, C.C.S.M. c. M110, s. 30(2).

<sup>75</sup> *Mental Health Act*, C.C.S.M. c. M110, s. 30(4).

<sup>76</sup> *Mental Health Act*, C.C.S.M. c. M110, s. 29(2).

<sup>77</sup> *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42, s. 79(4).

#### IV. VALID TREATMENT AUTHORIZATION DECISIONS

In jurisdictions which separate the authority to admit from the authority to treat, whoever makes the treatment decision, the patient or a substitute decision-maker, must make a “valid” decision. This includes not only decisions that are made at the time of the treatment but also “advanced directives” where, in Ontario for example, a person may make a decision to consent or refuse a treatment months or even years before the actual treatment is to be given.

To be valid, the consent must be given by a person capable of doing so, it must be informed, and it must not be coerced. Extensive discussion is available in Arboleda-Flórez and Copithorne.<sup>78</sup>

##### A. Capability of Making Treatment Decision

Some provinces allow an involuntary patient who is capable of making a treatment decision to do so, including refusing all treatment. Similarly, some allow a detained incapable patient who, when capable, expressed a valid wish not to be treated to refuse treatment by requiring the substitute decision-maker to follow the valid wish and refuse. Thus in jurisdictions where being found capable can result in the person not receiving treatment for the disorder for which the person was hospitalized and possibly extend the detention indefinitely, it is important that the issue of defining capability in the Act and in practice, be taken very seriously.

The test of capability varies among Canadian jurisdictions but, generally, it is that the person is capable of understanding and appreciating the consequences of accepting or rejecting the treatment. Three important questions in capability provisions will be discussed: (1) what is the definition of capability? (2) what level of capability is required? and (3) how much evidence is required to prove the person incapable? It should be noted that some jurisdictions use the word “competent” whereas others use “capable”. The two terms refer to the same concept and are used interchangeably. This text speaks of “capability” or “capacity” rather than “competence”.

##### 1. Definition of “Capability to Make a Treatment Decision”

The *Mental Health Acts* in Canada that define capacity to make a treatment decision do it somewhat like Alberta which provides:

...a person is mentally competent to make treatment decisions if the person is able to understand the subject-matter relating to the decisions and able to appreciate the consequences of making the decisions.<sup>79</sup>

There are some variations between the jurisdictions in their definition of capability, although many include the areas of understanding and appreciation that the examining physician must consider. Manitoba is typical of five jurisdictions:

<sup>78</sup> J. Arboleda-Flórez & M. Copithorne, *Mental Health Law and Practice* (Toronto: Carswell, 1994).

<sup>79</sup> *Mental Health Act*, R.S.A. 2000, c. M-13, s. 26.

In determining a patient's mental competence to make treatment decisions, the attending physician shall consider

- (a) whether the patient understands
  - (i) the condition for which the treatment is proposed,
  - (ii) the nature and purpose of the treatment,
  - (iii) the risks and benefits involved in undergoing the treatment, and
  - (iv) the risks and benefits involved in not undergoing the treatment; and
- (b) whether the patient's mental condition affects his or her ability to appreciate the consequences of making a treatment decision.<sup>80</sup>

Two differences among the definitions in Canadian jurisdiction appear to be significant on paper but whether they are significant in practice is unknown. The questions are: are both understanding and appreciation required? Does the person have to actually understand the issues or just have the "ability" to understand or appreciate?

**(a) Understanding and Appreciation — Both Required?**

In jurisdictions which require both understanding and appreciation the distinction between the two, at least in the Ontario *Health Care Consent Act (1996)*, was addressed by the Supreme Court of Canada. Justice Major writing for the majority in *Starson v. Swayze* stated:

...Capacity involves two criteria. First, a person must be able to understand the information that is relevant to making a treatment decision. This requires the cognitive ability to process, retain and understand the relevant information. There is no doubt the respondent satisfied this criterion. Second, a person must be able to appreciate the reasonably foreseeable consequences of the decision or lack of one. This requires the patient to be able to apply the relevant information to his or her circumstances, and to be able to weigh the foreseeable risks and benefits of a decision or lack thereof.<sup>81</sup>

In Ontario, the person must display both the ability to understand and the ability to appreciate. In the Yukon and Prince Edward Island,<sup>82</sup> there is no reference to "appreciate". It might be argued that an intelligent person with paranoid delusions who had read psychiatric textbooks could be, in the words of the Yukon Act, "able to understand" the condition, treatment and the risks of undergoing or refusing treatment. The person would have to be found capable even though they did not believe any of this applied to them because it was the CIA causing their problems. This is the reason that most provisions have the requirement for appreciation as well, since appreciation requires that the person apply or be able to apply the information to their own situation.

<sup>80</sup> Manitoba: *Mental Health Act*, C.C.S.M. c. M110, s. 27(2); *Mental Health Act*, R.S.N.B. 1973, c. M-10, s. 1(2); Nova Scotia: *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42, s. 18; P.E.I.: *Mental Health Act*, R.S.P.E.I. 1988, c. M-6.1, s. 23(3).

<sup>81</sup> *Starson v. Swayze*, [2003] S.C.J. No. 33 at para. 78, 2003 SCC 32 (S.C.C.).

<sup>82</sup> P.E.I.: *Mental Health Act*, R.S.P.E.I. 1988, c. M-6.1, s. 23(3); Yukon: *Mental Health Act*, R.S.Y. 2002, c. 150, s. 19.

**(b) Actual Versus Ability to Understand and Appreciate**

Some Acts require the patient to demonstrate only an *ability* to understand and not actual understanding. The Ontario Act requires the ability to understand and also to appreciate. In speaking of the ability to appreciate, Major J. of the Supreme Court of Canada observed:

Secondly, the Act requires a patient to have the ability to appreciate the consequences of a decision. It does not require actual appreciation of those consequences. The distinction is subtle but important .... In practice, the determination of capacity should begin with an inquiry into the patient's actual appreciation of the parameters of the decision being made: the nature and purpose of the treatment; the foreseeable benefits and risks of treatment; the alternative courses of action available; and the expected consequences of not having the treatment. If the patient shows an appreciation of these parameters — regardless of whether he weighs or values the information differently than the attending physician and disagrees with the treatment recommendation — he has the ability to appreciate the decision he makes:

However, a patient's failure to demonstrate actual appreciation does not inexorably lead to a conclusion of incapacity. The patient's lack of appreciation may derive from causes that do not undermine his ability to appreciate consequences. For instance, a lack of appreciation may reflect the attending physician's failure to adequately inform the patient of the decision's consequences ... . Accordingly, it is imperative that the Board inquire into the reasons for the patient's failure to appreciate consequences. A finding of incapacity is justified only if those reasons demonstrate that the patient's mental disorder prevents him from having the *ability to appreciate the foreseeable consequences of the decision*.<sup>83</sup>

This distinction between ability and actual may be difficult to make in practice. As McLachlin C.J.C. writing the minority opinion in this case, observes:

While the difference between ability to understand and appreciate and actual understanding or appreciation is easily stated, it may be less easy to apply in practice. Capacity is an abstract concept. The primary means of ascertaining capacity or ability, in any context, is to look at what an individual in fact says and does. It follows that it is not an error for the Board to inquire into the actual understanding or appreciation of the person in question.<sup>84</sup>

Manitoba, Nova Scotia and Prince Edward Island require the person to actually understand the treatment issues but only have the ability to appreciate, not necessarily actually appreciate, the consequences of making the decision.<sup>85</sup>

**2. Level of Capability Required**

The level of capability a person must possess in order to make a valid treatment decision depends upon the gravity of the consequences and the complexity of

<sup>83</sup> *Starson v. Swayze*, [2003] S.C.J. No. 33 at paras. 80-81, 2003 SCC 32 (S.C.C.) (underlining in original, italics added).

<sup>84</sup> *Starson v. Swayze*, [2003] S.C.J. No. 33 at para. 15, 2003 SCC 32 (S.C.C.).

<sup>85</sup> Manitoba: *Mental Health Act*, C.C.S.M. c. M110, s. 27(2); Nova Scotia: *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42, s. 18; P.E.I.: *Mental Health Act*, R.S.P.E.I. 1988, c. M-6.1, s. 23(3).

the illness and treatment issues. A person with dementia may be quite capable of consenting to having a bandage put on a cut leg but quite unable to understand that they have a heart condition that requires a pacemaker. Similarly, an involuntary patient with severe delusions may be quite capable of consenting to a minor operation but not capable of making a decision about psychiatric medications, especially where refusing them could result in him being detained indefinitely.

Three jurisdictions — Saskatchewan, Nova Scotia and Newfoundland and Labrador — specify a level of capability. In all other jurisdictions the assumption is that clinicians and courts will be guided by the complexity of the decision and the consequences in deciding “what level” of capability is required. The three provinces, that do specify a level of capability state that the person must “fully” understand. Nova Scotia for example, states that in relation to “admission and treatment decisions”, “the psychiatrist shall consider whether the patient fully understands and appreciates”.<sup>86</sup> These three provinces are the only ones that exclude a person from involuntary admission if they are capable. But the person must be fully capable. Obviously, there could be very serious consequences if a person with a mental disorder who was a strong physical threat were not admitted because the person was found to be capable on a low level of capability test.

Only British Columbia makes a distinction in level of capability required by involuntary patients who accept treatment and those who do not. The information about the treatment must be presented to each involuntary patient. If the patient agrees to accept the treatment the test is an understanding test: “capable of understanding the nature of the above authorization”. However, if the authorization is not signed by the patient, a higher level of capability, an appreciation test, is required: “... is incapable of appreciating the nature of treatment and/or his or her need for it, and is therefore incapable of giving consent”.<sup>87</sup>

It can be argued that when a person agrees to needed treatment the level of capability should be lower so that fewer people are declared incapable and people retain more autonomy. Conversely, if refusal can result in continued suffering and indefinite detention because of a law, then there should be a higher level of capability. This difference has been referred to as assent rather than consent. Winick, a noted U.S. commentator, has supported this distinction.<sup>88</sup>

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<sup>86</sup> Nova Scotia: *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42, ss. 17(e) and 18(1); Saskatchewan: *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1, s. 24(2)(a)(iii); Newfoundland and Labrador: *Mental Health Care and Treatment Act*, S.N.L. 2006, c. M-9.1, s. 17(1)(b)(ii)(B).

<sup>87</sup> *Mental Health Regulation*, B.C. Reg 233/99, Form 5 “Consent for Treatment (Involuntary Patient)”.

<sup>88</sup> B.J. Winick, “Competency to Consent to Treatment: the Distinction Between Assent and Objection” (1991) 28 *Houston L. Rev.* 15-61.

### 3. Standard of Proof

How much evidence do physicians, review tribunals and courts require in order to decide that the test of capability specified in the legislation has been met? The Yukon makes it clear: “In a proceeding under this Act before the board or a court, the standard of proof is proof on a balance of probabilities.”<sup>89</sup> The Supreme Court of Canada in *Starson v. Swayze* commented on the standard of proof required to displace capability in Ontario. This was in response to a lower court that had said the test should be higher than the balance of probabilities and had required “clear and cogent” evidence.<sup>90</sup> The judge reasoned that a lower standard might lead to people receiving unwanted psychiatric treatment. The converse argument is that making it difficult to find someone incapable would deprive many people of treatment without which they would be incarcerated indefinitely. Both the Ontario Court of Appeal and the Supreme Court of Canada disagreed with the lower court. Justice Major for the majority, with the concurrence of the minority, wrote “I agree with the Court of Appeal that proof is the civil standard of a balance of probabilities.”<sup>91</sup> Later a Consent and Capacity Board wrote: “Although the correct standard of proof to be applied was arguably obiter [comment] rather than a necessary part of the precise issue the Court decided — Professor S.’s capacity — the two issues are so closely related that applying a different standard of proof would be disregarding the clear and unanimous view of the Supreme Court.”<sup>92</sup>

It may be difficult in practice, especially where a level of capability is not specified, to distinguish the level of capacity from the degree of proof required. The important point is that both relate to the consequences of the decision. As Arboleda-Flórez and Copithorne note, “[s]ince the decision of the Supreme Court of Canada in *R. v. Oakes* accepted the ‘degrees of probability’ test, it is likely that the standard of proof in competency tests cannot be separated from the effect of the decision. The more serious the consequences of the decision, the greater proof of capacity required.”<sup>93</sup>

Another important consideration regarding capability for people with a psychiatric condition is that as the condition may vary even on a daily basis, so may capability to consent. The English Court of Appeal in *Re R. (a Minor)*<sup>94</sup> recognized this and ruled that it would be dangerous for a reviewing body to assess the person’s state of mind solely on her state of mind when the mental illness was in recession. Fluctuating capacity is recognized in the Ontario *Health Care Consent Act (1996)*: “A person may be incapable with respect to a

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<sup>89</sup> *Mental Health Act*, R.S.Y. 2002, c. 150, s. 38.

<sup>90</sup> *Starson v. Swayze*, [1999] O.J. No. 4483 at paras. 16 and 20, 22 Admin. L.R. (3d) 211, (Ont. S.C.J.).

<sup>91</sup> *Starson v. Swayze*, [2003] S.C.J. No. 33 at para. 77, 2003 SCC 32 (S.C.C.).

<sup>92</sup> Consent and Capacity Board, “Professor S, A Patient at Brockville Psychiatric Hospital” (February 16, 2005) at 11.

<sup>93</sup> J. Arboleda-Flórez & M. Copithorne, *Mental Health Law and Practice* (Toronto: Carswell, 1994) at 5-12.

<sup>94</sup> [1991] 4 All E.R. 177 (C.A.).

treatment at one time and capable at another.”<sup>95</sup> However, there is no guidance about what should happen when it is known that the person will cycle quickly between capability and incapability and the effect that can have, if strictly observed, on clinical practice and legal decisions.

### **B. Informed Consent**

The information given to a capable person, or to a person making decisions on an incapable person’s behalf, to make an informed decision should include the nature of the condition, the nature of the treatment, the expected benefits of the treatment, the material risks of the treatment including the material side effects, alternative courses of action, and the likely consequences of not having the treatment.

### **C. Non-Coerced**

Consent is not valid if it is coerced. If a prisoner were asked to consent to a treatment that he did not want but agreed to because of a promise that his sentence would be reduced, it would be an invalid consent because it is coerced. Where a person is a competent involuntary patient, it is almost true by definition that the person has refused both admission and treatment. While it is possible that the person changes their mind once in hospital on rational grounds, it appears more likely that it is the coercion of continuing detention in hospital if treatment is not accepted which is persuasive. The validity of the consent is then questionable. A similar analysis can be undertaken of a relative who initially refuses treatment but then, given the reality of lengthy hospitalization without treatment, consents. If consents are coerced because of the nature of the admission and consequences of the admission, it is another argument in favour of some sort of state-mandated consent mechanism.

## **V. ADVANCE DIRECTIVES AND INVOLUNTARY IN-PATIENTS (PREVIOUSLY EXPRESSED WISHES)<sup>96</sup>**

An advance directive is an instruction made by a person when capable of making that type of decision (*e.g.*, to be treated) that guides or binds a substitute decision-maker if the person becomes incapable of making the decision. Some provinces in Canada recognize advance directives for involuntary patients and some do not. To be valid, a pre-expressed wish (advance directive) to be treated or not treated when a person becomes incapable must meet the same requirements as a contemporaneous directive (*i.e.*, consent). A number of policy as well as operational questions arise for involuntary, but not voluntary, psychiatric patients if advance directives are recognized. Before discussing operational issues, the policy debate which has led a number of nations to establish non-binding (*i.e.*, may be overridden) advance directives, is outlined. In short, the policy debate centres around the fact that allowing advance

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<sup>95</sup> *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 15(2).

<sup>96</sup> Note: Advance directives are also discussed in the chapter on “Assisted Outpatient Treatment”, Chapter 8.



directives to be used to refuse treatment results in a number of very serious negative consequences for detained patients (see discussion on delay of treatment. In his article “The Psychiatric Protection Order for the ‘Battered Mental Patient’” in the prestigious British Medical Journal, Dr Szasz, the famous anti-psychiatrist, urges capable people to write advance directives to refuse all “future involuntary psychiatric hospitalization and treatment”.<sup>97</sup> The policy implications of advance directives which prohibit treatment for involuntary patients are described by U.S. commentator Paul Applebaum.<sup>98</sup> He analyses the *Hargrave v. Vermont*<sup>99</sup> case where an involuntary patient’s advance directive not to be treated was upheld under the *Americans With Disabilities Act* (the legal analysis is not directly applicable in Canada). Applebaum writes:

Advance directives have been one of the most promising innovations in recent years to give patients a greater voice in their psychiatric care...

One of the earliest proponents of advance directives, Thomas Szasz, a fierce critic of psychiatric diagnosis and treatment, suggested that people with mental disorders use advance directives to preclude future treatment especially treatment with medications. As Szasz saw it, if advance directives represented unalterable choices of competent patients, there would be no way to override the preferences embodied in the directives...

Today, few severely ill committed patients avoid treatment with medications, regardless of the legal standard in their jurisdiction. Hargrave could change that. If large numbers of patients were to complete advance directives such as Nancy Hargrave’s, declining all medications, hospitals might well begin to fill with patients whom they could neither treat nor discharge.

A policy change such as decried by Appelbaum in the U.S. would clearly take patient treatment back to the institutional no-treatment era of 50 years ago. Nevertheless, Ontario and the Territories jurisdictions have adopted this policy position in regard to advance directives for involuntary patients. In these jurisdictions, which do not allow advance directives to be overridden, incapable psychiatric patients can be incarcerated indefinitely in a “hospital” as occurred before the development of effective treatments. The manner in which different Canadian jurisdictions have addressed the potential conflict between advance directives legislation and compulsory mental health admission or treatment is addressed below.

Advance directives pose a number of operational level issues which sum up to: “How do you know, if you are a physician or substitute decision-maker, whether the pre-expressed wish was valid?” This is very important because acting on a wish that is not valid may harm the patient (*e.g.*, detain them in hospital unnecessarily) or result in a lawsuit for giving treatment that was invalidly authorized. At the time the advance directive was made, which may be any time after the person turned 16 years of age, the person must have been

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<sup>97</sup> T. Szasz, “The Psychiatric Protection Order for the “Battered Mental Patient” (2003) 327 British Medical Journal 1449-51.

<sup>98</sup> P.S. Appelbaum, “Psychiatric Advance Directives and the Treatment of Committed Patients” (2004) 55 Psychiatric Services at 751-63.

<sup>99</sup> 340 F. 3d 276 (2nd Cir. 2003).

capable and the decision informed and not coerced. Ontario legislation, although not typical of Canada, will be used to illustrate the issues.

### **A. How Is it Known That the Person was Capable At the Time?**

There is a presumption of capability in all jurisdictions. Ordinarily, when the physician is discussing contemporaneous treatment including its benefits and side effects with the patient, the physician can relatively easily decide, then and there, if there is evidence that the person is not capable. The physician's observations are usually recorded so that a reviewing tribunal or court has evidence on which to assess the physician's opinion. However, assume in the case of our hypothetical patient, Robert Burke, that the written advance directive not to receive any psychiatric medication under any circumstances was made three years prior to involuntary hospitalization, at a time when his paranoid symptoms were reemerging, without consultation with a professional and after reading anti-psychiatry literature and internet sites in his own room without witnesses. It would be virtually impossible to prove that he was incapable, even if he was.

### **B. How Is it Known That the Person Made an Informed Decision?**

A consent decision must be informed in order for the consent to be valid. In the contemporaneous situation it is relatively easy to inform the patient, who is sitting in the same room as the professional, about the effects of the proposed treatment and the alternatives of not being treated. How can Robert Burke's decision in his room without discussion be informed? Does he understand that without medication any future involuntary hospitalization, which he hates, will almost certainly be much longer than if he accepts treatment? Does the absence of that vital information amount to an uninformed and therefore invalid advance directive? Again with no witnesses there is no way of effectively disputing that his is a valid directive.

### **C. Approaches to the Problems with Advance Directives for Involuntary Patients**

British Columbia and Newfoundland and Labrador solve the problems caused by advance directives by not recognizing them in the *Mental Health Act* with respect to an involuntary patient's psychiatric treatment although allowing them for voluntary patients and for non-psychiatric treatment of involuntary patients. This is known as a "*Mental Health Act* override".

Other jurisdictions (*e.g.*, Manitoba and Nova Scotia) allow advance directives with no means of proving they were valid. They address the potential negative effects by providing that if following the advance directive would harm the involuntary patient or others then the person's best interests must guide the decision-making.<sup>100</sup> In Manitoba previously expressed wishes are also taken into

<sup>100</sup> Manitoba: *Mental Health Act*, C.C.S.M. c. M110, s. 28(4); Nova Scotia: *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42, s. 18.

account, if a physician appeals a refusal: “Before it makes an order under this section, the review board shall consider any wishes the patient expressed about the treatment while mentally competent, and whether or not the patient would now, given the circumstances, alter those wishes if competent to do so.”<sup>101</sup> While the Ontario *Health Care Consent Act* provides no means for requiring evidence that the advance directive was made by a capable person or was informed, it attempts to mitigate this by a contemporaneous test: the wish must be “applicable to the [current] circumstances”. For example, the Court of Appeal of Ontario held that an advance directive (capable wish) based on the experience of the person with older medications was not applicable to the circumstances of newer medications with fewer side effects and therefore there was no valid previously expressed wish. The decision-maker was required to use the best interests test.<sup>102</sup>

Interestingly, in Ontario, the *Substitute Decisions Act*, in contrast to the *Health Care Consent Act*, does require evidence that the person was capable of making an advance directive. The *Substitute Decision Act* requires the person making certain serious advance directives to have their capability to do so assessed by a professional assessor and their directives to be witnessed.<sup>103</sup> The reason for this is that these decisions can have very significant effects on the person’s life. It is not difficult to argue that a person making a decision under the *Health Care Consent Act* that may result in months or years of untreated illness detained in a hospital needs similar protection.

Some other countries provide involuntary patients with considerable control over their treatment, through advance directives, without thwarting the purpose of the legislation, to provide treatment in the least restrictive manner. Scotland recently adopted legislation under which a person may make an “advance statement” that must be in writing, be signed, and witnessed by a health care professional or lawyer who can confirm that the person was capable of making the advance statement. Even with these important safeguards, under the new Scottish law the advance statement is not binding on the physician. The treating physician “shall have regard to the wishes” and if these wishes are not followed must provide the reasons in writing and provide the patient and named relative and others with a copy.<sup>104</sup> New Zealand encourages advance directives but tells patients that they can be overridden.<sup>105</sup>

Balancing the wishes of the patient regarding treatment against the need to infringe on the patient’s autonomy and liberty as little as possible is a major issue which is discussed in more detail in this chapter, including the recommendations section.

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<sup>101</sup> *Mental Health Act*, C.C.S.M. c. M110, s. 30(4).

<sup>102</sup> *Conway v. Jacques*, [2002] O.J. No. 2333, 59 O.R. (3d) 737 (Ont. C.A.), leave to appeal to S.C.C. dismissed [2002] S.C.C.A. No. 341 (S.C.C.).

<sup>103</sup> *Substitute Decisions Act*, 1992, S.O. 1992, c. 30, s. 50.

<sup>104</sup> *Mental Health (Care and Treatment) (Scotland) Act*, A.S.P. 2003, c. 13, ss. 275, 276.

<sup>105</sup> “Advance Directives in Mental Health Care and Treatment”, Annex 9 WHO Resource Book on Mental Health, Human Rights and Legislation (World Health Organization, 2005) at 178-81.

## VI. EMERGENCY TREATMENT WITHOUT CONSENT

The *Mental Health Acts* of some provinces/territories have a specific provision authorizing emergency treatment (sometimes referred to as “restraint”) without consent. In other jurisdictions (*e.g.*, British Columbia), there is a reliance on powers to “control” in the statute or in common law that provide legal authority and protection for staff to give treatment or restraint where the health or safety of the patient, or safety of others, is likely to be seriously jeopardized.

## VII. TREATMENT DELAYS

Since treatment is the key for an involuntary patient to gain freedom and return to the community, delaying the start of treatment can have significant negative effects. The delay in starting treatment varies among jurisdictions from virtually no delay to delays as long as two or even seven years. There are three sources of potential delay in starting treatment: the method of obtaining consent, the actual decision made and the review and appeal provisions.

### A. Consent Procedure Delay

In British Columbia, Saskatchewan, and Newfoundland and Labrador the physician or the facility director authorizes the treatment and there are no delays. Where a tribunal authorizes treatment (New Brunswick), or the court (Quebec), there may be a delay of a few days before the decision is provided. However, in New Brunswick, prior to the tribunal’s decision, the attending psychiatrist may without consent give routine clinical medical treatment.<sup>106</sup> In jurisdictions that use a state model of treatment authorization, treatment is generally started as soon as it is clinically appropriate.

In the jurisdictions that use a substitute decision-maker, such as a guardian or relative, there can be delays — finding a person and then presenting the information that will allow them to reach an informed decision. While studies do not appear to have been published on delays caused by not being able to find the substitute decision-makers, it is not difficult to envision delays of a few days or a week, if relatives are away or do not qualify or do not wish to be involved, and there is no “reasonable availability” limit in the legislation. As a comment, it is somewhat curious as to why *Mental Health Acts* set strict and short time limits for admission and review procedures whereas the time limits for initiating treatment, which is essential for ending the detention and reducing suffering, are conspicuous by their absence.

### B. Decision Delay

In jurisdictions that utilize the state treatment authorization model, the decision is almost always to treat. Therefore, the decision itself does not cause a delay in starting treatment. Nor can the treatment be delayed by the patient or someone else asking for a review of the decision.

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<sup>106</sup> *Mental Health Act*, R.S.N.B. 1973, c. M-10, s. 7.1(4)(c).

In jurisdictions with private treatment authorization models, private substitute decision-makers can refuse treatment and must in some cases. Since treatment must not commence without consent, therefore the patient must stay detained, coping with the symptoms of the mental disorder, with no treatment except that which the hospital can justify as a response to an emergency or as restraint. How long the patient stays detained depends upon if and when the refusal can be overridden. The refusal can be overridden in some provinces and not in others. It depends upon the review and appeal provisions of the law and whether the hospital decides to pursue the obtaining of treatment or is content just to detain the patient. In jurisdictions where a capable patient's current treatment decision or valid, applicable previously expressed wish not to be treated cannot be overridden, the delay in treatment can be absolute.

### C. Reviews and Appeals Delay

A discussion of how review and appeal mechanisms work is found in Chapter 9 on rights and safeguards. Suffice it to say that even when the substitute decision-maker has consented to treatment, it cannot begin if the patient asks for a review. The review may be of the patient's capability to make a treatment decision in some jurisdictions (*e.g.*, Alberta) or an objection to the substitute decision-maker or to the treatment itself. Usually the review must be held within a reasonably short time (*e.g.*, seven days in Ontario and Alberta). Even if the review board upholds the treatment decision by confirming the patient's incapability, the patient can appeal the decision to the courts. Decisions of a lower court can then be appealed to a higher court. Alberta, though, does not permit an appeal of the court's decision.<sup>107</sup> Where appeals can proceed to the Supreme Court of Canada, as in Ontario, treatment can be significantly delayed. In one case, this process delayed treatment for nearly two years.<sup>108</sup> A five year delay occurred in the *Starson* case, see special section below on this case.

A study of delays in commencing treatment in Ontario<sup>109</sup> found that for people who asked the Consent and Capacity Board for a review, there was a delay on average of 23 days before treatment started. Parenthetically, it may be noted that a large proportion of patients who start treatment immediately would have been discharged in less than 23 days. For people who were found incapable by the Board and then appealed that finding to the court, the average delay in initiating treatment was over eight months (253 days). All of these people eventually received treatment because the court confirmed their incapability.

The Ontario Court of Appeal has commented on this problem. In a case where the man had already been 12 years in hospital "capably" refusing treatment, the review and appeal process took another five years. The court wrote:

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<sup>107</sup> *Mental Health Act*, R.S.A. 2000, c. M-13, s. 43(5).

<sup>108</sup> R.L. O'Reilly, "Mental Health Legislation and the Right to Appropriate Treatment" (1998) 43 *Can. J. Psychiatry* 811-15.

<sup>109</sup> M. Kelly *et al.*, "Treatment Delays for Involuntary Psychiatric Patients Associated with Reviews of Treatment Capacity" (2002) 47 *Can. J. Psychiatry* 181-85.

Finally, I must express my concern regarding unacceptable delay flowing from the protracted nature of these proceedings. Over five years has passed since Dr. Jacques first raised the issue of Paul Conway's psychiatric treatment with Francis Conway. I urge all concerned to do what is required to have the issue of Paul Conway's treatment resolved as soon as possible.<sup>110</sup>

Despite the admonition by the court for due haste the patient, or substitute decision-maker, appealed to the Supreme Court of Canada thereby further delaying treatment because, in Ontario, treatment cannot start until the final court decision is rendered. Treatment was commenced when, nearly seven months after the Ontario Court of Appeal decision, the Supreme Court of Canada denied leave to appeal.

#### **D. Examples of Consequences of Delays in Treatment for Involuntary Patients**

Treatment refusal for involuntary patients is a major issue from both the civil libertarian and human needs perspectives. Below are some selected cases reported in Canadian literature that illustrate the negative consequences, for patients, care-givers and society, of laws that permit treatment delay and refusal for detained patients. The *Starson* case, portrayed as a victory by "civil libertarian" advocates, is the first of the six cases chosen.

##### **1. "Professor" Starson — Supreme Court of Canada**

"Professor" Starson, whose case reached the Supreme Court of Canada in 2003,<sup>111</sup> had been detained continuously for seven years, all of it untreated, until he became in danger of dying because of delusionally induced starvation. His history illustrates what can happen when the psychiatric treatment necessary for release cannot be provided because of the law.<sup>112</sup>

Scott Jeffery Schutzman, born January 13, 1956, changed his name to Scott Starson in 1993 because he said he was the "son of a star" and, to this day, insists on being called "Professor" although he is not one. He graduated in 1976 as a specialist in electrical engineering from Ryerson Polytechnical Institute, Ontario. He worked for an international electrical engineering company, becoming its national sales manager, and was an accomplished athlete. When his case was heard, he had been jobless since the late 1980s. In the late 1980s he wrote some scientific papers, including co-authoring a paper with an

<sup>110</sup> *Conway v. Jacques*, [2002] O.J. No. 2333 at para. 41, 59 O.R. (3d) 737 (Ont. C.A.), leave to appeal to S.C.C. dismissed [2002] S.C.C.A. No. 341 (S.C.C.).

<sup>111</sup> *Starson v. Swayze*, [2003] S.C.J. No. 33, 2003 SCC 32 (S.C.C.).

<sup>112</sup> R.L. O'Reilly & J.E. Gray, "Most Important Lesson From *Starson* Ignored in Article" (2006) 27 *Health Law in Canada* at 36-40; J.E. Gray & R.L. O'Reilly, "Supreme Court of Canada's 'Beautiful Mind' Case" (Submitted for Publication) *International Journal of Law and Psychiatry*; Remarks of the Right Honourable Beverley McLachlin, P.C., Chief Justice of Canada, "Medicine and the Law: The Challenge of Mental Illness", 2004 Honourable Mr. Justice Michael O'Byrne/AHFMR Lecture on Law, Medicine and Ethics, University of Alberta and University of Calgary, February 17 and 18, 2005 online: <[http://www.scc-csc.gc.ca/aboutcourt/judges/speeches/medecine\\_law\\_e.asp](http://www.scc-csc.gc.ca/aboutcourt/judges/speeches/medecine_law_e.asp)>.

internationally respected physicist in 1991.<sup>113</sup> In 1985, at age 29, Scott Starson, had his first admission to a psychiatric hospital. In the following 13 years he had more than 20 admissions, most of them involuntary. The symptoms included grandiose delusions and threats of harm to others. The diagnosis was usually bipolar disorder, although more latterly, schizoaffective disorder.

Scott Starson's continuous seven-year incarceration in hospital started when he was charged with two counts of uttering death threats in 1998. He was found unfit to stand trial. Under the *Criminal Code* the judge directed, on the basis of medical advice, "that a specific treatment should be administered to the accused for the purpose of making the accused fit to stand trial".<sup>114</sup> Even if the person is capable of refusing treatment, has an advance directive to refuse treatment or the substitute decision-maker refuses, all of which Ontario civil legislation allows, the *Criminal Code* overrides these: "The court may direct that treatment of an accused be carried out pursuant to a disposition made under section 672.58 [unfit to stand trial] *without the consent* of the accused or a person who, according to the laws of the province where the disposition is made, is authorized to consent for the accused."<sup>115</sup> Starson responded to the compulsory treatment to the point that he became fit to stand trial. At the trial he was found Not Criminally Responsible on Account of Mental Disorder ("NCRMD") and became the responsibility of the Criminal Code Ontario Review Board which directed him to be detained in a forensic unit of a psychiatric hospital.

Scott Starson refused treatment and was found incapable by physicians and by the Consent and Capacity Board. Some of his delusions at the time were summarized by the Chief Justice of the Supreme Court of Canada as follows:

He talks about plans to run the "Starson Corporation" from inside his current inpatient unit; insists that he is "leading on the edge of efforts to build a starship"; claims to be a world-class skier and arm-wrestler; and has asserted that he is the greatest scientist in the world and communicates with extra-terrestrials. While Professor Starson would not agree, his illness appears to have progressed and his condition has deteriorated.<sup>116</sup>

Despite these delusions, other symptoms of a serious mental illness, findings of incapability and recommendations from psychiatrists for treatment, Starson could not be treated under Ontario law, because there was an outstanding appeal to the court. He was found by three courts including the Ontario Superior Court of Justice, the Ontario Court of Appeal and finally the Supreme Court of Canada to be capable of making a treatment decision.<sup>117</sup>

Justice Major writing for the majority in the Supreme Court of Canada in June 2003, appears to have accepted Starson's reasons for refusing medication:

<sup>113</sup> This material is taken from C. Spencer, "In the Name of Freedom", MDCanada, September/October 2003 at 38-52.

<sup>114</sup> *Criminal Code*, R.S.C 1985, c. C-46, s. 672.59(1).

<sup>115</sup> *Criminal Code*, R.S.C 1985, c. C-46, s. 672.62(2) (emphasis added).

<sup>116</sup> *Starson v. Swayze*, [2003] S.C.J. No. 33 at para. 2, 2003 SCC 32 (S.C.C.).

<sup>117</sup> *Starson v. Swayze*, [1999] O.J. No. 4483, 22 Admin. L.R. (3d) 211 (Ont. S.C.J.) (Molloy J.), aff'd [2001] O.J. No. 2282, 201 D.L.R. (4th) 123 (Ont. C.A.); aff'd [2003] S.C.J. No. 33, 2003 SCC 32 (S.C.C.).

“His primary reason for refusing medication was its dulling effect on his thinking, which prevented his work as a physicist” and rejected the Consent and Capacity Board finding that he was incapable. A minority of three justices, including the Chief Justice, disagreed. Thus, after five years of refusing treatment for his serious psychiatric illness, the court found Starson to be capable and Starson went on refusing treatment while continuing to be confined in a forensic psychiatric unit.

Did Starson, once free of any threat of psychotropic medication, return to his scientific work as Major J. implied he would? Was he released like he said he would be? Did he get better? Did his problems go away? The short answer is, no, he got worse, very much worse. Chief Justice Beverley McLachlin, in a public speech<sup>118</sup> nearly two years later, stated:

Starson’s mother was reported to be devastated by the Court’s decision, saying that her son’s life and dreams have been destroyed.<sup>119</sup> An account of subsequent interviews with Professor Starson and an appearance before the Ontario Review Board would seem to indicate that his mental health is not improving.<sup>120</sup> Following his latest Review Board hearing in December of last year, Professor Starson was again found to constitute a real and substantial danger to the public. As a result, the Board ordered his continued detention in a psychiatric hospital.<sup>121</sup> Professor Starson may well never recover from the illness that afflicts him and may spend the rest of his life in custody or under the significant control of the criminal justice system. Hence the cruel paradox – freedom to refuse “medication” may in fact result in institutional confinement and continued debilitation. Is this true autonomy?<sup>122</sup>

Lacking treatment for his brain illness, things got even worse for Starson as described by the Chief Justice. Not only did he do no scientific work but also his delusions worsened and he nearly died. At a Consent and Capacity Board hearing on February 9, 2005, Starson’s psychiatrist stated:

He had severe paranoid delusions, thinking that the hospital was poisoning his food and drink, which was leading him to eating very little and drinking very little with profound loss of weight as a result....if we don’t get some antipsychotic treatment into this man very soon he will certainly die.<sup>123</sup>

<sup>118</sup> Remarks of the Right Honourable Beverley McLachlin, P.C. Chief Justice of Canada, “Medicine and the Law: The Challenge of Mental Illness” 2004 Honourable Mr. Justice Michael O’Byrne/AHFMR Lecture on Law, Medicine and Ethics, University of Alberta and University of Calgary, February 17 and 18, 2005, online: <[http://www.scc-csc.gc.ca/about-court/judges/speeches/medecine\\_law-e.asp](http://www.scc-csc.gc.ca/about-court/judges/speeches/medecine_law-e.asp)>.

<sup>119</sup> See Sue Bailey, “Man Hailed by Some as Genius Cannot be Forcibly Drugged for Mental Illness”, online: <<http://www.cp.org/english/online/full/National/030606/n0606120A.html>>.

<sup>120</sup> See Christina Spencer, “In the Name of Freedom”, MD Canada, September/October 2003.

<sup>121</sup> *Re Scott Schutzman a.k.a. Starson*, ORB File No. 2852, December 10, 2004.

<sup>122</sup> Remarks of the Right Honourable Beverley McLachlin, P.C., Chief Justice of Canada “Medicine and the Law: The Challenge of Mental Illness” 2004, Honourable Mr. Justice Michael O’Byrne/AHFMR Lecture on Law, Medicine and Ethics, University of Alberta and University of Calgary, February 17 and 18, 2005 at 27, online: <[http://www.scc-csc.gc.ca/aboutcourt/judges/speeches/medecine\\_law\\_e.asp](http://www.scc-csc.gc.ca/aboutcourt/judges/speeches/medecine_law_e.asp)>.

<sup>123</sup> “In the matter of the Health Care Consent Act, 1996 etc and in the matter of Professor S., a patient at Brockville Psychiatric Hospital Brockville Ontario”, Reason for Decision February 16, 2005, KI-05-4875.



An independent medical specialist's opinion was also cited at the hearing:

Patient has not had any fluid intake in the past 20 hours. He refuses to drink or eat any nutrition offered to him on every opportunity...this man is metabolically unstable and resides in an emergency physical state...I am concerned if emergency measures to rehydrate are not followed he will not make his Boards or be capable of psychiatric treatment.

The Consent and Capacity Board confirmed his psychiatrist's opinion that Starson was incapable. Because his previously expressed wish, as evidenced by his continuous refusal of treatment that he said dulled his mind, did not apply to the new circumstances of dying from delusionally induced starvation, his previously expressed wishes did not have to be followed. The best interests test applied and his mother, who was his substitute decision-maker, consented to the compulsory treatment. And so this brilliant man with a treatable psychiatric illness who had remained continuously incarcerated and untreated in a psychiatric facilities for over seven years (apart from a short time when compulsory medication rendered him fit to stand trial) finally received the psychiatric treatment that numerous psychiatrists and his mother had been advocating for him for years.

Did the medication that Starson had successfully battled against for seven years dull his mind and do terrible things to him as he claimed and as some judges appeared to concur with or did his symptoms and functioning improve as predicted by the psychiatrists?

Starson, by now lying on his death bed, was treated with injectable Haldol. The Ontario Review Board reported:

The accused's concentration level has improved. He has abandoned his bed and attends with staff into the Brockville community and the hospital grounds. Although he has lost a fair amount of his paranoid thinking, particularly his grandiosity, he still retains some grandiose ideas. His weight has increased to 160 pounds from 118 pounds in the space of just over 2 months.<sup>124</sup>

Two years later, from a July 16, 2007 hearing, following a move to a less secure forensic psychiatric unit, the Ontario Review Board reported:

With respect to insight, Dr. Darby noted that Mr. Starson acknowledges that he requires antipsychotic medication and may require this medication for the balance of his life...since approximately a year and a half to two years, there has been no concern about verbal aggression...Mr. Starson is on long acting injectable medication, Respidol Consta that Mr. Starson has never refused. This medication is more tolerable with fewer side effects. ...he will be found capable to consent to treatment. Mr. Starson is expected to move to an apartment.<sup>125</sup>

Despite this significant progress, Mr. Starson continued to show some depressive symptoms, was not particularly social and there was a concern about non-compliance given his more than ten-year history of refusing medication. The Board did not discharge him but rather ordered the hospital to assist Mr. Starson to become established in an apartment in the community. While staff expressed optimism that he would continue with this medication, if Mr Starson

<sup>124</sup> *Re Schutzman*, [2005] O.R.B.D. No. 1841 at para 20 (Ont. Rev. Bd.).

<sup>125</sup> *Re Scott Starson (Schutzman)*, [2005] O.R.B.D. No. 2852 (Ont. Rev. Bd.).

when capable refused treatment, under Ontario law the cycle could well be repeated.

## 2. Self-Mutilation Case: Dr. Chandrasena

Chandrasena described a case of self-mutilation caused by untreated schizophrenia:

S. presented himself at St Michael's Hospital and was admitted, requiring emergency treatment for damage to his right eye. He informed the staff in the emergency department that he had tried to pluck out his eye. The patient was involuntarily committed to hospital and retained for approximately four months without treatment as of the time of the appeal hearing. . . . It was apparent from all of the evidence before the court, which was also before the Board, that the patient's attempt to pluck out his right eye was due to his belief in certain passages in the Bible. There was also evidence before the court and the Review Board that he intended to cut off his right hand, and there was some suggestion that he was considering cutting off his right foot.<sup>126</sup>

Counsel for the patient argued that the patient was competent to refuse treatment and that he should not be treated. Decisions of the review board and of a court against the patient were appealed. For the appeal court, Hawkins J. wrote:

No one can quarrel with a cancer patient's refusal to take chemotherapy treatment whether that refusal is based on a refusal to admit the illness. The present situation is grotesque. The deeply troubled young man who has already maimed himself once and who clearly is in danger of repeating the attempt has been confined for over seven months. The treatment proposed is not radical. No one is suggesting shock therapy or lobotomy. The neuroleptic medication proposed has some uncomfortable but not life threatening side effects. His continuing confinement without treatment is turning an active treatment hospital into a custodial facility.<sup>127</sup>

If this young man, referred to by the court as being in a "grotesque" situation, had made a valid competent wish not to be treated in jurisdictions which do not allow such decisions to be overturned (*e.g.*, Ontario), he could not have been treated. The only legal option would be to physically or chemically restrain him to prevent him from self-mutilating.

## 3. Violent Man with Schizophrenia: Dr. Chan and Dr. Conacher

Chan and Conacher described the history of a young and violent patient with schizophrenia who was refused treatment because of a pre-expressed, apparently competent wish. This resulted in assault charges, a forensic hospital admission, two psychiatric hospital admissions and a continuing threat to the community. The authors put the dilemma for clinicians and for society this way:

<sup>126</sup> *S. v. Joffe* (May 11, 1988), Doc. Toronto 52588/88, Gotlib J. (Ont. Dist. Ct.) in R. Chandrasena, "The Other Mental Health Act: A Review of District Court 'Competence' Decisions" (1991) 12 Health Law in Canada 15 at 16, 17.

<sup>127</sup> *S. v. Joffe* (May 11, 1988), Doc. Toronto 52588/88, Gotlib J. (Ont. Dist. Ct.) in R. Chandrasena, "The Other Mental Health Act: A Review of District Court 'Competence' Decisions" (1991) 12 Health Law in Canada 15 at 18.

Although the patient had expressed a wish not to be treated at a time when he was allegedly competent, it must be questioned how informed his decision was at the time. Could he have been in any way aware that the consequences of his decision would provoke a bewildering round of arrests, court appearances, quasi-judicial board hearings, emergency room attendances, futile hospital admissions and bare motel rooms? Delayed treatment significantly affects the prognosis for ultimate recovery from psychosis and as his delusions become more entrenched, what hope has his recorded “competent” wish left him for any form of ordinary happiness? Is there no humane alternative in a supposedly caring society to seeing our resource depleted psychiatric hospitals revert to the mere physical containment of untreated psychotic patients?”<sup>128</sup>

#### 4. Psychotic Patients in Jail: Dr. McCaldon *et al.*

McCaldon, Conacher and Clark described two patients, both with schizophrenia, in a prison situation, one sentenced to five years for assault and the other seven years for manslaughter. They concluded:

Because of the complications inherent in the *Mental Health Act* and the delays involved in applying for legal aid, determined and paranoid patients can defer the treatment process for over 7 months. During this time they remain psychotic, delusional and so dangerous that they must be confined in small cells and never allowed to exercise, go to the library, watch television or socialize with anyone. They see only the people who pass their cell and may spit on them or throw urine or feces. They may yell accusations all night and disturb other patients, who may become so aggravated that they are likely to pitch boiling water through the bars, a recognized retribution in prison culture.<sup>129</sup>

These authors describe dangers to patients and staff because of the use of emergency chemical restraint which is allowed under the *Mental Health Act* without consent where necessary if treatment cannot be provided and physical restraint becomes too inhumane. Another case is described where an untreated patient remained in seclusion (solitary confinement) for five months because he was threatening and assaultive. His appeal was rejected and after two weeks of treatment, he was cooperative and rational. He was able to go to the gymnasium and the library, and mingle with fellow inmates.

#### 5. Nearly Two Years Detained: Dr. O’Reilly

O’Reilly described a patient who was detained in an Ontario psychiatric hospital for nearly two years because he was untreated, despite his wife providing treatment authorization.<sup>130</sup> During the nearly two years that the patient was detained and not treated, he remained extremely paranoid and uncooperative. He threatened his wife and assaulted her once, causing her to fear for her life and to change residence. Although he had responded well to medication on a previous admission, he stopped treatment soon after discharge and refused medication on

<sup>128</sup> M.P. Chan & G.N. Conacher, “Legally Untreatable — A New Category of Long Stay Patient?” (1994) 39 *Can. J. Psychiatry* 433 at 434.

<sup>129</sup> R.J. McCaldon, G.N. Conacher & B.J. Clark, “The Right to Remain Psychotic” (1991) 145 *Can. Med. Assoc. J.* 777 at 780.

<sup>130</sup> R.L. O’Reilly, “Mental Health Legislation and the Right to Appropriate Treatment” (1998) 43 *Can. J. Psychiatry* 811-15.

the second admission. He made separate requests to the review board on the appropriateness of certification and his incapability status. When the board upheld both certificates, he appealed to the Ontario District Court and then to the Court of Appeal, which did not grant leave for appeal. On the 570th day of admission, still untreated, he appealed to the Supreme Court of Canada which, on day 699, dismissed the leave for appeal, but it was not until day 718 that the written judgment reached the hospital. When permission to treat was finally received from the court, it took over three months to get him well enough to leave the hospital. This is much longer than would probably have been the case had treatment been initiated when he was admitted. On regaining insight from the psychosis, O'Reilly reported:

... the patient signed a living will, in which he requested that, if he ever became ill again, he be given prompt treatment with medication so as to "avoid wasting my time with a lengthy hospitalization due to my inability to decide on being treated".<sup>131</sup>

#### 6. 404 Days in Seclusion: *Sevels v. Cameron*

In *Sevels v. Cameron*,<sup>132</sup> Sevels, who had been diagnosed with paranoid schizophrenia, was not treated because his substitute decision-maker was required by the legislation to follow his apparently competent, previously expressed wish not to be treated. As the judge put it: "Because of the symptoms of his disease including violent behaviour, Mr. Sevels has been in seclusion at the Mental Health Centre as of the date of application for 404 days." The judge concluded from the evidence before him that the medication for which permission was sought would normalize Sevels' thinking, stabilize his mood and lessen his extremely violent behaviour. Furthermore, in the past, Sevels had tolerated the medication well with few side effects. The judge wrote ". . . the conclusion is that the proposed treatment will substantially outweigh any possibility of harm that might be occasioned to the patient".<sup>133</sup> However, the judge did not authorize the treatment, despite expressing his concern about the legislation that allowed people with schizophrenia who could not help themselves to be "caged and warehoused", because he was bound by the Ontario Court of Appeal's *Fleming v. Reid*<sup>134</sup> decision.

### VIII. CHARTER CASES ON TREATMENT ISSUES UNDER *MENTAL HEALTH ACT*

No cases regarding the constitutionality of overriding the treatment refusal of, or on behalf of, a involuntary patient have reached the Supreme Court of Canada. *Mental Health Acts* in a number of provinces allow treatment refusals to be overridden but Ontario does not. The difference between Ontario and other jurisdictions probably lies in the purpose of the Acts. The *Starson* case in

<sup>131</sup> R.L. O'Reilly, "Mental Health Legislation and the Right to Appropriate Treatment" (1998) 43 Can. J. Psychiatry 811 at 814.

<sup>132</sup> [1994] O.J. 2123 at para. 1 (Ont. Gen. Div.).

<sup>133</sup> [1994] O.J. 2123 at para. 3 (Ont. Gen. Div.).

<sup>134</sup> [1991] O.J. No. 1083, 4 O.R. (3d) 74 (Ont. C.A.).

Ontario is sometimes incorrectly interpreted<sup>135</sup> as affirming a capable involuntary patient's right to refuse medications. However, this was not a constitutional case as Major J., for the majority, wrote "Neither party raised the constitutionality of the Act as an issue in this appeal."<sup>136</sup> The case was about whether Starson was capable of making a treatment decision under the Ontario *Consent and Capacity Act*. That Ontario Act has always laid out clearly that a capable patient does have the absolute right to refuse treatment. The Supreme Court of Canada decision in *Starson* had no direct implication for mental health law in other jurisdictions.<sup>137</sup>

Earlier in this chapter two approaches to treatment decision making were described: private authorization and state authorization. There appear to be no reported court cases challenging the state authorization of treatment using a "best interests" test in Saskatchewan or Newfoundland and Labrador. In British Columbia, a Charter challenge to the state authorization treatment model did not succeed because the court ruled that the challenger did not have standing.<sup>138</sup> Similarly, in private authorization jurisdictions, there appear to be no court cases challenging the use of "best interests". In Alberta the sole criterion is best interests and in Manitoba and Nova Scotia best interests apply if following previously expressed wishes would seriously harm the patient or others. Aboleda-Flórez and Copithorne, after reviewing a number of English cases including the House of Lords (the highest court of appeal in England), concluded: "The *Bland* case also firmly established the English version of the best interests test over the substituted judgement [competent wishes] test, although a patient's previously expressed views will be an important component of the decision of physicians or courts."<sup>139</sup> Indeed many foreign democratic jurisdictions use best interests and do not recognize previously expressed capable wishes.<sup>140</sup> In Ontario, the best interests test is used where previously expressed wishes are unknown: a Charter challenge on this use of the best interests test for incapable involuntary patients did not succeed.<sup>141</sup>

Regarding private authorization, the leading case in Ontario on the issue of whether the substitute decision-maker must follow the competent wishes of the patient, even if to do so results in harm or unnecessary detention, or whether the decision should be made in the patient's best interests, is *Fleming v. Reid*.<sup>142</sup> This 1991 case is important not just because of its interpretation of the law in Ontario

<sup>135</sup> "The Court is Right to Uphold Autonomy of Capable Patients", *Vancouver Sun*, Editorial (June 10, 2003) at A12: "Now that the case has been resolved and a capable patient's right to refuse medication affirmed ...".

<sup>136</sup> *Starson v. Swayze*, [2003] S.C.J. No. 33 at para. 75, 2003 SCC 32 (S.C.C.).

<sup>137</sup> S.A. Brooks, R.L. O'Reilly & J.E. Gray, CPA Advisory, "Implications for Psychiatrists of the Supreme Court of Canada *Starson v. Swayze* Decision" (August 2003) CPA Bulletin at 28.

<sup>138</sup> *Mullins v. Levy*, [2005] B.C.J. No. 1878, 2005 BCSC 1217 (B.C.S.C.).

<sup>139</sup> J. Arboleda-Flórez & M. Copithorne, *Mental Health Law and Practice* (Toronto: Carswell, 1994) at 5-41.

<sup>140</sup> *Mental Health (Care and Treatment) (Scotland) Act*, A.S.P. 2003, c. 13; *Mental Health (Compulsory Assessment and Treatment) Act 1992* (N.Z.); *Mental Health Act 1993*, No. 59 of 1993, (South Australia).

<sup>141</sup> *Conway v. Jacques*, [2002] O.J. No. 2333, 59 O.R. (3d) 737 (Ont. C.A.).

<sup>142</sup> [1991] O.J. No. 1083, 4 O.R. (3d) 74 (Ont. C.A.).

but because its reasoning and dicta (non-binding comments) have been interpreted by some to mean that non-consensual treatment for an involuntary patient admitted under a *Mental Health Act*, if there is a valid wish not to be treated, may not be possible from a constitutional point of view in Canada.

The finding of the Ontario Court of Appeal in *Fleming v. Reid* was that the Ontario *Mental Health Act*<sup>143</sup> provisions for overturning treatment refusals were unconstitutional. The court therefore struck down that part of the Act. The particular concern was that when a substitute decision-maker made a decision, the *Mental Health Act* required the decision to be in accordance with the apparently capable expressed wishes of the person, if these were known. However, the review board did not have a statutory obligation to consider these wishes and only considered the patient's best interests. The court found this unacceptable and not otherwise justifiable in a free and democratic society (section 1 of the Charter).

Hoffman described the circumstances of *Fleming v. Reid*. Reid was being held in maximum security after being found not guilty, on account of a mental disorder. He was psychotic at the time and was not being treated:

In the 1991 *Fleming v. Reid* case, the Official Guardian, appointed as proxy for a mentally incompetent patient under Ontario's *Mental Health Act*, refused to provide consent for the administration of antipsychotic medication, based on the patient's previous wishes expressed while the patient was apparently competent. The mental health review board initially overrode the PGT's [Public Guardian and Trustee] decision to refuse treatment because the board had a legislated mandate to make decisions that were deemed to be in the best interests of the patient and, consequently, approved the treatment. The Ontario Court of Appeals, however, ultimately ruled that neither the review board nor the patient's physician had the right to totally disregard the previously expressed wishes of the capable patient. The Court ruled that the Ontario legislation was in error because it did not instruct the board to consider the previously expressed wishes of the patient while capable.

This case exhibits how seriously Canadian courts have viewed wishes and advance directives as signs of the patient's autonomy and as more important than the patient's best interests, judged by others. The ruling remains problematic from clinical and ethical perspectives. Although Mr. Reid had refused neuroleptic medications earlier in his illness while, apparently, mentally capable, it is difficult to believe that he would have envisioned the possibility that he would become psychotic, kill someone [sic], be held in a maximum security psychiatric facility and in solitary confinement indefinitely because he repeatedly exhibited psychotic and dangerous behaviour when he was not given neuroleptics. This case speaks loudly to the danger of advance directives being applied in circumstance that a person could not foresee.<sup>144</sup>

The challenge of *Fleming v. Reid* from a mental health policy perspective is summed up in the penultimate paragraph of the judgment of the Ontario Court of Appeal:

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<sup>143</sup> R.S.O. 1990, c. M.7.

<sup>144</sup> B.F. Hoffman, *The Law of Consent to Treatment in Ontario*, 2nd ed. (Toronto: Butterworths, 1997) at 84.

The right to personal security is guaranteed as fundamental in our society. Manifestly, it should not be infringed any more than is clearly necessary. In my view, although the right to be free from non-consensual psychiatric treatment is not an absolute one, the state has not demonstrated any compelling reason for entirely eliminating this right, without any hearing or review, in order to further the best interests of involuntary incompetent patients in contravention of their competent wishes. To completely strip these patients of the freedom to determine for themselves what shall be done with their bodies cannot be considered a minimal impairment of their *Charter* right. Safeguards can obviously be formulated to balance their wishes against their needs and ensure that their security of the person will not be infringed any more than is necessary. Recognizing the important objective of state intervention for the benefit of mentally disabled patients, nonetheless, the overriding of a fundamental constitutional right by the means chosen in this Act [the Ontario *Mental Health Act*] to attain the objective cannot be justified under s. 1 of the *Charter*.<sup>145</sup>

Arboleda-Flórez and Copithorne summarized the challenge of the court: “The *Fleming* judgment implies that, without legislative provisions establishing criteria for assessment of the effect or scope of a patient’s prior competent wishes, a refusal based on those wishes must stand.”<sup>146</sup>

### A. Comments on *Fleming v. Reid* Judgment

Before taking up the challenge to provide compelling reasons to override a treatment refusal after having considered a patient’s previously expressed competent wishes, and to propose mechanisms which can do so while minimally impairing the person’s Charter right to security of person, and “balance their needs against their wishes”, the following analysis is provided of the *Fleming v. Reid* decision. This analysis will caution against extrapolating the court’s decision and dicta to other jurisdictions that, unlike Ontario, have mental health legislation with a treatment rather than a detention purpose. In brief, it is suggested that the court, by relying on faulty information, reached incorrect conclusions about the nature of psychotropic medication, and did not consider the effect of treatment refusal on other Charter rights. The court also did not appear to take into account the harmful consequences of treatment refusal for detained patients.

#### 1. Nature of Psychiatric Treatment: Effectiveness, Side Effects, Effects of Not Treating

In relation to psychiatric treatment, the Ontario Court of Appeal stated:

Few medical procedures can be more intrusive than the forcible injection of powerful mind-altering drugs which are often accompanied by severe and sometimes irreversible adverse side effects.<sup>147</sup>

Presumably, in making this pronouncement, the court did not have the benefit of comparable evidence about other medical procedures which are dangerous,

<sup>145</sup> [1991] O.J. No. 1083, 4 O.R. (3d) 74 at 96 (Ont. C.A.).

<sup>146</sup> J. Arboleda-Flórez & M. Copithorne, *Mental Health Law and Practice* (Toronto: Carswell, 1994) at 5-21.

<sup>147</sup> *Fleming v. Reid*, [1991] O.J. No. 1083 at para. 40, 4 O.R. (3d) 74 (Ont. C.A.).

invasive or embarrassing, and which have very serious irreversible side effects including ablation of healthy tissue, amputations, treatment of severe epilepsy by destruction of brain tissue, loss of ability to walk and perform other physical and intellectual functions, disfigurement and severe pain. The court also did not note that compulsory psychiatric medication is usually taken orally without force and that forced injections are relatively rare. In making a proper analysis, the side effects of a medical procedure must be considered in relation to the seriousness of the condition and the therapeutic effects of the treatment, and not by themselves.

In reaching these negative conclusions about psychotropic medication, the court considered some material written by people with a strong anti-psychiatry bias who are not accepted as experts by their professional peers. For example, Breggin's paper "Brain Damage Dementia and Persistent Cognitive Dysfunction Associated With Neuroleptic Drugs: Evidence, Etiology, Implications" was placed before the court.<sup>148</sup> Breggin has been described as the "chief disciple" of the Szasz (mental illness is a myth) theory and has stated that psychiatric medications "permanently damage the higher centers of the brain, producing irreversible psychoses, apathy, generalized brain dysfunction, dementia and effects similar to those resulting from lobotomy".<sup>149</sup> But Breggin, like Szasz, does not believe in the reality of psychosis which, according to Breggin, reflects "utter irresponsibility for one's own thought processes and personal conduct. It is the ultimate expression of personal failure or abject psychological helplessness."<sup>150</sup> Breggin's article was presented to the court in *Fleming v. Reid* by counsel for the patient, one of whom was Carla McKague, who has documented her own anti-psychiatry views.<sup>151</sup>

The court used the pejorative term "mind altering" to describe these medications. However, "mind altering", as the court itself said, is beneficial:

Because the therapeutic effect of the drugs is to reduce the level of psychotic thinking, it is virtually undisputed that they are "mind altering". Although neuroleptics are the drug of choice for treatment of patients diagnosed as schizophrenic, they are not a cure for the disorder but are said to work so as to have a beneficial effect on thought processes and the brain's ability to sort out and integrate perceptions and memory.<sup>152</sup>

The *Fleming v. Reid* court was speaking of anti-psychotic drugs as "mind altering" in a positive sense. Other courts have misapplied the statement in *Fleming v. Reid*. For example, the Supreme Court of Canada majority judgment in *Starson v. Swayze* only uses the pejorative quote: "Few medical procedures can be more intrusive than the forcible injection of powerful mind-altering drugs which are often accompanied by severe and sometimes irreversible adverse side

<sup>148</sup> P. Breggin, "Brain Damage Dementia and Persistent Cognitive Dysfunction Associated With Neuroleptic Drugs: Evidence, Etiology, Implications" (1990) 11 J. Mind and Behavior 425.

<sup>149</sup> P. Breggin, *Psychiatric Drugs: Hazards to the Brain* (New York: Springer, 1983) at 2.

<sup>150</sup> P. Breggin, quoted in R.J. Isaac & V.C. Arnot, *Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill* (New York: Free Press, 1990) at 229.

<sup>151</sup> I. Shimrat, *Call Me Crazy: Stories from the Mad Movement* (Vancouver: Press Gang Publishers, 1997) at 61.

<sup>152</sup> *Fleming v. Reid*, [1991] O.J. No. 1083 at para. 24, 4 O.R. (3d) 74 (Ont. C.A.).



effects.”<sup>153</sup> That the *Fleming* court used “mind altering” to mean “the therapeutic effect of the drugs is to reduce the level of psychotic thinking” was not alluded to by the Supreme Court.

The Ontario Court of Appeal overstated the negative side effects of anti-psychotic medication. It is true that tardive dyskinesia can be permanent, although often it stops with medication discontinuation. It is not true that these medications are “often accompanied by severe” side effects. These medications are often accompanied by mild side effects, many of which clear up after a short period, and only sometimes by severe side effects. This is especially true of the newer atypical anti-psychotic medications that have come into common usage after the court’s decision. Again, the side effects must be contrasted with the effects of not taking the medications which can include homicide, as apparently was the case with Reid, lengthy periods detained in hospital, dangerousness to themselves and others, and suffering. A more balanced conclusion is that placed before the U.S. Supreme Court:

The overwhelming preponderance of data supports a high benefit to risk ratio for these medications and a safety record commensurate with other powerful pharmacologic agents.<sup>154</sup>

Unless expert witnesses provide courts with modern scientific and balanced information, it is likely that future courts will continue to be influenced by the outdated and biased information on medications available to the *Fleming* court. The risk of perpetuating inaccurate information is greater now that, 12 years later, the Supreme Court of Canada, has repeated the *Fleming* quotations, even though a whole new class of antipsychotic drugs have come into widespread use. The problem of courts not keeping up with advances in science and repeating the erroneous “findings” of another court, has attracted comment in the U.S. Davoli has documented evidence in an article entitled *Still Stuck in the Cuckoo’s Nest: Why Do Courts Continue to Rely on Antiquated Mental Illness Research*.<sup>155</sup>

As the Chief Justice of the Supreme Court of Canada said in a lecture: “The challenge for the law is to keep pace with the medical developments and ensure that the legal regime governing mentally ill persons is responsive to the current state of scientific knowledge.”<sup>156</sup> But it is incumbent on medical professionals

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<sup>153</sup> *Starson v. Swayze*, [2003] S.C.J. No. 33, 2003 SCC 32 at para. 75 (S.C.C.).

<sup>154</sup> Supreme Court of the United States, *State of Washington v. Walter Harper*, paper for the American Psychiatric Association and the Washington State Psychiatric Association as *Amici Curiae*, at 16.

<sup>155</sup> J.H. Davoli, “Still Stuck in the Cuckoo’s Nest: Why Do Courts Continue to Rely on Antiquated Mental Illness Research?” (2002) 69 *Tenn. L. Rev.* 987. See also S.J. Brakel & J.M. Davis, “Taking Harms Seriously: Involuntary Mental Patients and the Right to Receive Treatment” (1991) 25 *Ind. L. Rev.* 429-73 at 440.

<sup>156</sup> Remarks of the Right Honourable Beverly McLachlin, P.C. Chief Justice of Canada, “Medicine and the Law: The Challenge of Mental Illness” 2004 Honourable Mr. Justice Michael O’Byrne/AHFMR Lecture on Law, Medicine and Ethics, University of Alberta and University of Calgary, February 17 and 18, 2005 at 33, online: ><http://www.scc-csc.gc.ca/about-court/judges/speeches/medicine-law-e.asp>>.

and others to put this information before courts since courts can only rule on the evidence before them.

## 2. Charter Rights Not Considered by Court

### (a) Liberty Right

In *Fleming v. Reid*, the court appeared to have concentrated its analysis solely on the “security of the person” phrase in section 7 of the Charter and did not consider the implications of compulsory treatment of involuntary patients on the “liberty” right in section 7. Section 7 reads:

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.

As noted, the court took great exception to injections with drugs as being a violation of the security of the person. However, these medications are the only means scientifically proven to restore the involuntary patient’s liberty that has been restricted by the state because of the mental disorder. The right to liberty is also a Charter right. Detention does not, by itself, have any effect on psychotic symptoms or potential for inflicting harm. Detention contains the potential danger but does not prevent it or treat it. Detention, by definition, interferes with the liberty right, although detention under *Mental Health Act* legislation does not compromise section 7 because liberty is restricted in accordance with the principles of fundamental justice.<sup>157</sup> Similarly, it could be argued that deprivation of the security of a person which restores liberty, as is possible with non-consensual psychiatric treatment, is in accordance with the Charter as long as the treatment is carried out in accordance with the principles of fundamental justice.

### (b) Freedom of Thought Right

The court also did not consider another Charter freedom which psychosis interferes with and which is set out in s. 2(b) as follows:

Everyone has the following fundamental freedoms: ...

(b) freedom of thought, belief, opinion and expression, including freedom of the press and other media of communication; ...

Paranoid delusions, command hallucinations, illogical thoughts, ideas of reference, melancholic mood and manic mood are all common symptoms of schizophrenia and severe mood disorders which can result in people being involuntarily hospitalized. These symptoms profoundly affect thought, indeed they control thought in the sense that the person cannot have normal thoughts. Thought in these conditions is not free in the sense of being rational, analytical and showing proper judgment. For example, the delusion that the CIA is controlling a person’s every act is more powerful than the thought control envisioned in “brainwashing”.

<sup>157</sup> *McCorkell v. Riverview Hospital*, [1993] B.C.J. No. 1518, [1993] 8 W.W.R. 169, 81 B.C.L.R. (2d) 273 (B.C.S.C.).

These abnormal controlled thoughts frequently take over the life of the person and can be so powerful as to drive a person to homicide, self-mutilation or suicide. Thus, severe mental illnesses deprive people of a fundamental freedom identified by the Charter — freedom of thought.

Detention in a psychiatric facility does not treat or improve the deprivation of the “freedom of thought” caused by a psychotic process. In fact, forced hospitalization may make psychotic symptoms worse because delusions, for example, that the person is being persecuted, may be exacerbated and reinforced by detention. As was noted in the *Fleming v. Reid* judgment, neuroleptics are the drug of choice for schizophrenia because they have a beneficial effect on thought processes, perception and memory.<sup>158</sup> The court appears to acknowledge the fact that schizophrenia interferes with the freedom of thought and medication restores that freedom, even if there are side effects.

The reason the state deprives people of liberty under a *Mental Health Act* is that their thoughts are controlled by a mental illness that is likely to result in serious harm to themselves or others. If legislation denies the hospital the right to treat the cause of the thought control, the law is denying the possibility of restoring a person’s fundamental freedom, the freedom of thought. Such a law frustrates the reason for admission, the restoration of the freedom of thought and, it could be argued, therefore, is not in accord with section 2(b) of the Charter.

**(c) Freedom from Cruel and Unusual Treatment or Punishment Right**

Section 12 of the Charter states:

Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.

Individuals such as Sevels, in *Sevels v. Cameron*,<sup>159</sup> because of dangerous behaviour when not treated, may have to be kept in solitary confinement for long periods. Since treatment would enable them to be freed from confinement, does the treatment refusal amount to a violation of their right “not to be subjected to cruel and unusual treatment or punishment”?

As Savage and McKague writing from a civil libertarian perspective stated:

To date, what judicial commentary on this section [12] has existed has applied largely to the criminal justice system. One wonders what the courts’ attitude would be in the non-criminal realm. For instance, if someone who is obviously disordered and being detained for recovery, both in his or her interest and in society’s interest, is not accorded adequate treatment which would facilitate recovery, would the detention constitute punishment either cruel or unusual? It is unlikely that it would carry the epithet “unusual”, but it might well fall into the category of being “cruel”. The United States District Court in the case of *Matarella v. Kelley* decided that detaining non-criminals for compulsory treatment or for other legitimate purposes such as protection of society without

<sup>158</sup> *Fleming v. Reid*, [1991] O.J. No. 1083, 4 O.R. (3d) 74 at 84 (Ont. C.A.).

<sup>159</sup> [1994] O.J. No. 2123 (Ont. Gen. Div.).

implementing a treatment program was a violation of the Eighth Amendment's prohibition against cruel and unusual punishment.<sup>160</sup>

It can be argued that a law forcing a hospital to keep a psychotic individual in solitary confinement for 404 days (at the time the court considered his case, it may have been much longer),<sup>161</sup> when that is unnecessary and when an alternative is "immediately at hand" according to the court, causes cruel and unusual treatment. The patient and others might also regard it as cruel and unusual punishment. While seclusion was a commonly used procedure to manage aggressive patients in psychiatric hospitals prior to the mid-1950s, before psychotropic medications were developed, its use is now restricted to those few individuals who do not respond to these drugs or refuse to take them. Long-term seclusion is not only uncommon; it is also unusual in that the professionally recognized standard for treating schizophrenic symptoms is not seclusion but anti-psychotic medication. Having established that long-term seclusion rather than anti-psychotic medication is an "unusual" treatment, is it "cruel"? To be placed in solitary confinement for long periods in a hospital as a treatment would be considered by most professionals, psychiatrists and nurses as cruel. A survey of patients who had been secluded reported: "respondents left little doubt that it was a universally horrific experience".<sup>162</sup> Such "treatment", it might be argued, could be described today as "excessive", and might "infringe standards of decency and morality", be "inhuman" and "repulsive, or offensive" — concepts used to test whether a treatment should be considered to breach section 12 of the Charter.<sup>163</sup>

This analysis might be extended from locking a person in a room (seclusion), to detaining them in a hospital rather than treating them and discharging them. Certainly, to be detained in a hospital for nearly two years, as was the patient in O'Reilly's example,<sup>164</sup> when the average length of stay for that condition is about a month, is unusual treatment. If the patient wanted to return to work and to his family, he could well have perceived hospitalization as cruel, and indeed may easily have perceived it to be cruel punishment. It can thus be concluded that there is an argument to be made that laws which allow treatment refusal where the alternative "treatment" is restrictive in restraint, seclusion or unnecessary detention violate the right to be free from "cruel and unusual treatment or punishment".

#### **(d) Equality Right**

Section 15(1) of the Charter states:

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,

<sup>160</sup> H. Savage & C. McKague, *Mental Health Law in Canada* (Toronto: Butterworths, 1987) at 69.

<sup>161</sup> [1994] O.J. No. 2123 (Ont. Gen. Div.).

<sup>162</sup> B. Trott & P. O'Loughlin, "Voices of Experience: Thoughts About B.C.'s Mental Health Law From Those Who Have Directly Experienced It" (1991) *Community Legal Assist. Society* at 16.

<sup>163</sup> *Azhar v. Anderson* (June 28, 1985), Doc. 609/85 at 20 (Ont. Dist. Ct.).

<sup>164</sup> R.L. O'Reilly, "Mental Health Legislation and the Right to Appropriate Treatment" (1998) 43 *Can. J. Psychiatry* 811-15. Consider also Professor Starson's detention of over seven years.

without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Could it be argued that where the law allows treatment refusal because of which an involuntary psychiatric patient is unnecessarily detained for long periods, that person is denied a benefit available in jurisdictions that require the state to treat detained patients and restore their liberty interests? In Saskatchewan, the physician has an obligation to “provide the person with care and treatment as a result of which the detention of the person in the facility will no longer be required”.<sup>165</sup>

**(e) Guarantee of Rights and Freedoms (Override)**

Section 1 of the Charter states:

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.

If it is determined that an involuntary patient’s capably expressed wish to refuse treatment cannot be overridden because it would violate a Charter right, it is still possible for the procedure authorizing non-consensual treatment to be in accord with the Charter if it is a limit prescribed by law that can be demonstrably justified in a free and democratic society. A number of democratic countries have, within their mental health statutes, mechanisms for authorizing treatment without consent, or overruling the refusal of capable patients or refusals of substitute decision-makers based on the patient’s capably previously expressed wishes. Most countries do not have an absolute right to refuse treatment. The New Zealand *Mental Health (Compulsory Assessment and Treatment) Act* provides for an in-patient order, issued by a judge on the recommendation of a physician, that “. . . shall require the patient to accept that treatment”.<sup>166</sup> The England and Wales *Mental Health Act 1983* states:

The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, not being treatment falling within s. 57 [lobotomy] or 58 [treatment longer than three months] above, if treatment is given by or under the direction of the responsible medical officer.<sup>167</sup>

According to Appelbaum, some U.S. states limit the right to the refusal of inappropriate medication.<sup>168</sup> In South Australia, a physician may authorize treatment in the short term “notwithstanding the absence or refusal of consent to the treatment”.<sup>169</sup> For longer-term treatment a board makes the decision on a best interests test.<sup>170</sup> The *Mental Health (Care and Treatment) (Scotland) Act* proclaimed in 2005<sup>171</sup> contains similar provisions.

<sup>165</sup> *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1, s. 27.

<sup>166</sup> *Mental Health (Compulsory Assessment and Treatment) Act 1992*, No. 46 (N.Z.), s. 30.

<sup>167</sup> *Mental Health Act 1983* (U.K.), c. 20, s. 58(3).

<sup>168</sup> P.S. Appelbaum, *Almost a Revolution* (New York: Oxford University Press, 1994) at 129.

<sup>169</sup> *Mental Health Act 1993*, No. 59 (South Australia), s. 18.

<sup>170</sup> *Mental Health Act 1993*, No. 59 (South Australia), s. 20.

<sup>171</sup> *Mental Health (Care and Treatment) (Scotland) Act*, A.S.P. 2003, c. 13.

While many other democratic countries recognize the problem of allowing treatment refusal for psychiatric patients who have been admitted because, without treatment, they are likely to cause harm to themselves or others and to be detained indefinitely, those cited here should be sufficient to establish the point relevant to section 1 of the Charter. In fact, what appears to be unusual, among democratic jurisdictions, are Canadian jurisdictions that have laws that could compel a person with a severe mental illness to be kept in seclusion for over 404 days and not be treated with universally recognized safe and effective medication. Even a court, when refusing a request to treat because of Ontario law and the *Fleming v. Reid* decision, commented:

...However, in dismissing the application I express the view that it surely cannot be the intended result of the application of the *Charter of Rights and Freedoms* that persons who are entrapped in the cage of their mental illness and who are medically diagnosed as chronically unable by the nature of their disease to give or refuse informed consent with respect to treatment, whether or not they are from time to time able to function in other aspects of their lives, *be for prolonged periods caged and warehoused in mental health facilities where the key to their necessary and involuntary seclusion is available with relatively little likelihood of substantial risk.*<sup>172</sup>

## IX. SERIOUS HARMS ARISING FROM TREATMENT REFUSAL

The *Fleming v. Reid*<sup>173</sup> court discussed the negative effects of medication, but it did not consider the negative effects of refusing treatment. When capable involuntary patients or the substitute decision-makers of incapable involuntary patients refuse treatment, real and serious harms can and do occur to the patient, fellow patients, staff, family, the health care system and society.

Before beginning a description and analysis of the harmful effects of treatment refusal, it is important to clarify the meaning of compulsory treatment for an involuntary psychiatric patient. A person being considered for involuntary treatment was involuntarily admitted by a process with a number of built-in safeguards including the certification criteria (*e.g.*, mental disorder, serious harm, need for treatment, and so forth) and the committal procedures (*e.g.*, two medical certificates for hospitalization longer than a few days). The involuntary admission is without consent and overrides any previously expressed competent wishes by the patient not to be admitted. Also, no one can refuse the admission on the patient's behalf.

The psychiatric treatments that may be refused, are antipsychotic, antimanic, mood stabilizers and other medications or procedures that are the standard for good medical practice, endorsed by regulatory and medical authorities in Canada and throughout the world. These medications are taken voluntarily by hundreds of thousands of people in hospitals and in the community in all democratic countries. It is the treatment needed by an involuntary patient to recover to the point of not meeting the involuntary detention criteria of mental health legislation. These treatments do have side effects, some serious, as do most medical treatments of illnesses that have high disability and death rates.

<sup>172</sup> *Sevels v. Cameron*, [1994] O.J. 2123 at para. 15 (Ont. Gen. Div.) (emphasis added).

<sup>173</sup> [1991] O.J. No. 1083, 4 O.R. (3d) 74 (Ont. C.A.).

There are no known alternative, scientifically effective treatments for treating acute psychosis. Compulsory treatment is rarely physically forced treatment. Compulsory treatment with medications is as effective in controlling psychotic symptoms (*e.g.*, hallucinations, aggression) as is voluntary treatment.

## A. Negative Effects on Involuntary Patients

### 1. Increased Patient Suffering

People being driven to suicide by untreated depression, or cowering in response to accusatory voices, suggests that mental illnesses are frequently painful. The high suicide rate of people with schizophrenia (1 in 10) can be attributed to reactions to command hallucinations, frightening delusions and despair. Judge Tobias in a judgment on Gallagher, the other patient involved in treatment refusal in *Fleming v. Reid*, stated:

...Kenneth Gallagher, I find, is suffering indescribable agony as an uncontrolled psychotic, isolated from the only world he has come to know. I have no hesitation in making the order requested to provide to him as much normalcy and dignity as possible, pending the outcome of the appeal, in the knowledge that the countervailing risks in his particular case, appear to be minimal.<sup>174</sup>

Similarly, Gallagher's psychiatrist's opinion quoted by the court said:

...This man is floridly psychotic. It is ludicrous to lock him up and not treat him. As psychiatrists, we have a very effective (albeit not perfect) treatment — neuroleptic medication — for this man's problems. He desperately needs treatment. . . . This patient (and others in the same tragic bind) must not be allowed to be abused while the courts decide about patients' rights to decline treatment interventions. This poor man is totally unable to fend for himself. It is a travesty to call him "not guilty" and then allow this florid psychosis to occur untreated in a "Mental Health Centre" . . . If Oak Ridge is to be a psychiatric facility, and not just a big cage, you must be given the right to treat patients like Kenneth James Gallagher.<sup>175</sup>

To refuse treatment for involuntary patients with these symptoms promotes suffering. Information provided later shows that this suffering can be prolonged for long periods of time by legislation allowing treatment refusal.

### 2. Increased Use of Restraints and Seclusion

Patients universally express their loathing of restraints and seclusion.<sup>176</sup> However, nurses in Ontario report that restraint use increases with treatment refusal.<sup>177</sup> In a controlled study:

A review of restraints required for the two groups revealed that refusers were significantly more likely to be restrained ( $n = 44$  [47%]), whether the technique employed in question was seclusion, physical restraint, or chemical restraint, than control patients ( $n = 18$  [19%]) ( $\chi^2 = 15.8$ ,  $df = 1$ ,  $P = 0.001$ ).

<sup>174</sup> *Sevels v. Cameron*, [1994] O.J. 2123 at para. 4 (Ont. Gen. Div.).

<sup>175</sup> *Sevels v. Cameron*, [1994] O.J. 2123 at para. 4 (Ont. Gen. Div.).

<sup>176</sup> B. Trott & P. O'Loughlin, "Voices of Experience: Thoughts About B.C.'s Mental Health Law From Those Who Have Directly Experienced It" (1991) *Community Legal Assist. Society* at 16.

<sup>177</sup> J. Trimmell, "The Need to Treat" (1988) 8 *Health Law in Canada* 102-103.

.....

Of the patients who were restrained, each refuser had significantly more episodes of restraint than did each non-refuser (control group mean, 1.6 and SD = 0.97; refusers: mean, 3.4 and SD = 4.0) ( $t = 3.61$ ,  $df = 58$ ,  $P = .001$ ).<sup>178</sup>

These results were confirmed in a similar study in another jurisdiction.<sup>179</sup>

### 3. Longer Stay in Hospital

A well-controlled study of 1,434 psychiatric patients found that the length of stay of refusers was approximately twice as long as the stay of those who accepted treatment:

Patients who refused antipsychotic medication were hospitalized significantly longer than control subjects ( $t = 3.8$ ,  $df = 193$ ,  $P = 0.000$ ). The difference between the mean lengths of hospitalization for these groups ( $26.1 \pm 38.9$  vs  $49.4 \pm 46.1$  days)<sup>180</sup> was not accounted for solely by length of the refusal episode (mean length, 13 days).

Similar findings emerged from a similar controlled study in a different jurisdiction.<sup>181</sup> Reference was previously made to the patient who was detained for nearly two years in an Ontario hospital because of treatment refusal and who took about three months to get better when compulsory treatment was finally allowed.<sup>182</sup> In one Ontario study, patients waiting for the courts to rule on their capability were detained on average 253 days before they even started treatment.<sup>183</sup> This is much longer than usual for patients treated immediately upon admission who have an average length of stay of approximately 21 days.

### 4. Poorer Prognosis

The results of a classic study on the long-term effects of not providing medications to people with schizophrenia are summarized by Brakel and Davis.

May found that those patients who did not initially receive drugs for the six month period did substantially worse during the following three to five years, spending almost twice as much time in the hospital as did initially medicated patients . . . The data collected by May suggest that once deterioration occurs, it may be irreversible. May's results are reliable. Patients were randomly assigned

<sup>178</sup> S.K. Hoge *et al.*, "A Prospective, Multicenter Study of Patients' Refusal of Antipsychotic Medication" (1990) 47 Arch. Gen. Psychiatry 949 at 951, 952.

<sup>179</sup> J.A. Kasper *et al.*, "Prospective Study of Patients' Refusal of Antipsychotic Medication Under a Physician Discretion Review Procedure" (1997) 154 Am. J. Psychiatry 483-89.

<sup>180</sup> S.K. Hoge *et al.*, "A Prospective, Multicenter Study of Patients' Refusal of Antipsychotic Medication" (1990) 47 Arch. Gen. Psychiatry 949 at 951.

<sup>181</sup> J.A. Kasper *et al.*, "Prospective Study of Patients' Refusal of Antipsychotic Medication Under a Physician Discretion Review Procedure" (1997) 154 Am. J. Psychiatry 483-89.

<sup>182</sup> R.L. O'Reilly, "Mental Health Legislation and the Right to Appropriate Treatment" (1998) 43 Can. J. Psychiatry 811-15.

<sup>183</sup> M. Kelly *et al.*, "Treatment Delays for Involuntary Psychiatric Patients Associated with Reviews of Treatment Capacity" (2002) 47 Can. J. Psychiatry 181-85.



to the different samples so that the groups were strictly comparable. Evaluations of outcome were done “blind” and are thus objective and unbiased.<sup>184</sup>

Delay of treatment caused by refusal or waiting for appeals is particularly deleterious for youth or young adults experiencing their first psychotic break. Delayed treatment may disrupt the person’s education and vocational career and social relations. In studying delays in treatment for first-episode schizophrenia, Loebel concluded:

Duration of psychosis before treatment may be an important predictor of outcome in first-episode schizophrenia. Acute psychotic symptoms could reflect an active morbid process which, if not ameliorated by neuroleptic drug treatment, may result in lasting morbidity.<sup>185</sup>

## B. Negative Effects on Other Patients

Trimnell reported that, in Ontario, unmedicated psychotic patients were very frightening to other patients on the ward, interfering with their treatment and quality of life.<sup>186</sup> Similarly, the Hoge study determined that:

In 50% of patients (33/66), the refusal episode was noted to have a negative effect on the ward milieu. Of these patients, in 60% (20/33) the effect was due to disruptive behaviour on the part of the patient, in 12% (4/33) it was secondary to assaultiveness, in another 12% to withdrawn, psychotic behaviour, and in 16% (5/33) to other negative factors.<sup>187</sup>

Similar results were found in a replication of the above study in a different jurisdiction.<sup>188</sup>

## C. Increased Assaults on Nurses and Others

Khan and Trimnell both writing on the Ontario experience with treatment refusal cite increased assaults on nurses as a major problem.<sup>189</sup> Other studies support the conclusion that treatment decreases assaultiveness:

Refusers as a group had a significantly higher rate of assaults and threats of assault (49 vs 15 incidents among control patients).<sup>190</sup>

<sup>184</sup> S.J. Brakel & J.M. Davis, “Taking Harms Seriously: Involuntary Mental Patients and the Right to Refuse Treatment” (1991) 25 *Ind. L. Rev.* 429 at 457.

<sup>185</sup> A.D. Loebel, *et al.*, “Duration of Psychosis and Outcome in First Episode Schizophrenia” (1992) 149 *Am. J. Psychiatry* 1183 at 1183.

<sup>186</sup> J. Trimnell, “The Need to Treat” (1988) 8 *Health Law in Canada* 102-103.

<sup>187</sup> S.K. Hoge, *et al.*, “A Prospective, Multicenter Study of Patients’ Refusal of Antipsychotic Medication” (1990) 47 *Arch. Gen. Psychiatry* 949 at 952.

<sup>188</sup> J.A. Kasper, *et al.*, “Prospective Study of Patients’ Refusal of Antipsychotic Medication Under a Physician Discretion Review Procedure” (1997) 154 *Am. J. Psychiatry* 483-89.

<sup>189</sup> P. Khan, “Implications for Nursing Practice of Recent Changes to the Ontario Mental Health Act” (1988) *Health Law in Canada* 21-22; J. Trimnell, “The Need to Treat” (1988) 8 *Health Law in Canada* 102-103.

<sup>190</sup> J.A. Kasper *et al.*, “Prospective Study of Patients’ Refusal of Antipsychotic Medication Under a Physician Discretion Review Procedure” (1997) 154 *Am. J. Psychiatry* 483-89.

## D. Additional Resources Required for Treatment Refusers

There are four types of additional resources required for patients when treatment is refused. These include costs for keeping the patient and other patients safe; costs for additional days of hospitalization including lost opportunity cost because of blocked beds; poorer prognosis costs; and costs associated with the review process.

### 1. Additional Nursing Costs

Patients who refuse treatment require more nursing care because of higher use of seclusion and other forms of labour intensive restraint and monitoring. In addition, because these patients are more assaultive to nurses and other patients, it follows that Workers Compensation Board payouts for injured nurses and legal damages for assaults on other patients resulting in injuries are real possibilities.

### 2. Costs for Additional Days of Hospitalization

The additional costs of hospitalizing patients who refuse treatment is easy to see in an individual case. O'Reilly reports costs for the man detained nearly two years: "I have estimated that the cost of keeping this patient in hospital was approximately \$330,000 and this does not include the cost of legal services. It is unconscionable in these days of fiscal cutbacks to spend such a sum to ensure a patient does not get treatment!"<sup>191</sup> If the law had permitted medically indicated treatment, the cost would have been about a month of treatment or \$15,000. Kelly *et al.* estimated that for the 15 patients who had to wait an average of 253 days untreated for their court review, \$1,333,000 could have been saved if treatment had been started immediately after the review board confirmed incapacity. If treatment had been started before the review board had met the saving would have been \$3,867,000.<sup>192</sup> While the length of stay in these cases is unusual, two studies show that the length of stay for those who refused treatment was approximately twice that of those who did not refuse.<sup>193</sup> The implication is that it likely costs at least twice as much to hospitalize involuntary patients who refuse or have treatment refused for them. Given that about 10 per cent of involuntary patients in jurisdictions that allow treatment refusal will refuse, this is not an inconsequential societal cost.<sup>194</sup>

<sup>191</sup> R.L. O'Reilly "Mental Health Legislation and the Right to Appropriate Treatment" (1998) 43 *Can. J. Psychiatry* 811-15; O'Reilly's personal communication with J. Gray, November 19, 1999 (e-mail).

<sup>192</sup> M. Kelly *et al.*, "Treatment Delays for Involuntary Psychiatric Patients Associated with Reviews of Treatment Capacity" (2002) 47 *Can. J. Psychiatry* 181-85.

<sup>193</sup> S.K. Hoge *et al.*, "A Prospective, Multicenter Study of Patients' Refusal of Antipsychotic Medication" (1990) 47 *Arch. Gen. Psychiatry* 949 at 952; J.A. Kasper, *et al.*, "Prospective Study of Patients' Refusal of Antipsychotic Medication Under a Physician Discretion Review Procedure" (1997) 154 *Am. J. Psychiatry* 483-89.

<sup>194</sup> P.S. Appelbaum, *Almost a Revolution* (New York: Oxford University Press, 1994) at 134.

It could be argued that these are not true cost saving because the beds would be occupied by other patients if not by the treatment refusers. However, “blocked” beds represent an important lost “opportunity” cost. In these days of great pressure on psychiatric beds throughout Canada, many patients could use these blocked beds and reduce the human and financial cost of untreated mental illnesses. In the example of O’Reilly’s patient, approximately 20 patients could have been treated in the one bed given an average length of stay of one month.

### 3. Poorer Prognosis Costs

There is evidence that shows treatment refused or delayed negatively impacts prognosis. Poorer prognosis results in more rehospitalizations, higher treatment costs in the community, higher policing, prison and forensic hospitalization costs and costs associated with unemployment such as housing and welfare. This does not include private costs borne by families coping with difficult behaviour looking after their family member. The total financial burden of schizophrenia alone has been estimated in Canada at \$2.35 billion (1996).<sup>195</sup>

### 4. Review Process Costs

There is a financial cost involved in any review and appeal process, irrespective of the type of process employed. While there appear to be no studies of the cost of treatment refusal-related reviews or appeals in Canada, there are some U.S. studies. Hoge *et al.* report that in an 18-month period in Massachusetts, 2,273 petitions for judicial review required 10,500 hours of lawyers’ time, 3,000 hours of paralegal time and 4,800 hours of clinical staff time.<sup>196</sup> For estimation purposes, if all staff time is costed at an arbitrary \$75 per hour, the total is \$1,372,500, a not inconsequential amount, which does not include court time costs.

It is important to note that despite all these costs in Massachusetts, and in other jurisdictions, over 90 per cent of refusals were overturned by the court in the U.S. Indeed, in a number of studies 100 per cent were.<sup>197</sup> In a study in Ontario, 100 per cent of the cases were overturned by the court despite patients waiting, detained, on average for 253 days.<sup>198</sup> This raises the question of what is achieved by the lengthy, expensive and clinically unnecessary hospitalizations and deprivations of liberty and significant lawyer and court costs associated with the process.

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<sup>195</sup> R. Goeree *et al.*, “The Economic Burden of Schizophrenia in Canada” (1999) 44 Can. J. Psychiatry 464-72.

<sup>196</sup> S.K. Hoge *et al.*, “A Prospective, Multicenter Study of Patients’ Refusal of Antipsychotic Medication” (1990) 47 Arch. Gen. Psychiatry 949 at 955.

<sup>197</sup> R.L. O’Reilly & J.E. Gray, “Can We Justify Delays in Initiating Treatment for Involuntary Patients?” (2003) 2 Research Insights 1-10.

<sup>198</sup> M. Kelly *et al.*, “Treatment Delays for Involuntary Psychiatric Patients Associated with Reviews of Treatment Capacity” (2002) 47 Can. J. Psychiatry 181-85.

## X. FURTHER CHARTER CONSIDERATIONS ON RIGHT TO REFUSE TREATMENT

In making a case under the Charter for the involuntary treatment of involuntary patients, the following issues should be considered: the logical link between involuntary admission and compulsory treatment; the obligation under a *Mental Health Act* to provide treatment; *Mental Health Acts* that require “need for treatment” as a condition of certification; when consent for treatment is not required; voluntary patients not being the same as involuntary patients; the treatment refuser trap; and the potential for unprofessional conduct and negligence.

### A. Logical Link between Involuntary Admission and Compulsory Treatment

There is a logical link between involuntary admission and compulsory treatment. In the words of the Saskatchewan Law Reform Commission:

Civil commitment exists to provide treatment for seriously disturbed patients. If treatment cannot be provided by the facility to which the patient has been committed, there is no jurisdiction for continuing the committal. Logically, therefore, authority to direct hospitalization without consent of the patient must entail authority of some form of treatment without consent.<sup>199</sup>

United States commentators Brakel and Davis wrote:

The act of commitment to a hospital takes away freedom and can only be based on the fact that these patients suffer from mental illness to such an extent that they will not voluntarily seek appropriate treatment either as outpatients or in hospital on a voluntary basis. The court, in overriding the patient’s right to freedom assumes, indeed decides, the patient’s incompetence as to treatment decisions. If it were otherwise, the commitment statutes would be merely statutes for preventive detention.<sup>200</sup>

Rozovsky and Rozovsky in their Canadian consent law text stated:

The issue which has not always been dealt with is the rationale behind enforced hospitalization. If it is merely to remove the individual from society, then the involuntary hospitalization should be directed only at removal. If it is to treat the patient, it would be illogical to commit the individual to a hospital and then allow the person to refuse treatment if he is capable of consenting. . . . This creates a problem in that an individual is placed against his will in a hospital which has the main purpose of treating in order to affect a cure to remove the reason for the person being committed. By allowing the person to refuse treatment, the rationale for the committal is thwarted.<sup>201</sup>

Kaiser, while apparently not in favour of non-consensual treatment, provided a foundation for it when he wrote:

<sup>199</sup> Saskatchewan Law Reform Commission, “Proposals for a Compulsory Mental Health Care Act” (1985) at 7.

<sup>200</sup> S.J. Brakel & J.M. Davis, “Taking Harms Seriously: Involuntary Mental Patients and the Right to Receive Treatment” (1991) 25 *Ind. L. Rev.* 429 at 469.

<sup>201</sup> L.E. Rozovsky & F.A. Rozovsky, *The Canadian Law of Consent to Treatment* (Toronto: Butterworths, 1990) at 44, 45.

There is some potential for founding a right to treatment based upon the *Charter*. For example, detaining a person without providing adequate treatment could be argued as a violation of s. 7 of the *Charter*, using the *quid pro quo* formulation which has been accepted in the United States. Detention without treatment as partial compensation would be argued as a prolongation of state intrusion, without the provision of treatment as partial compensation for detention.<sup>202</sup>

### **B. Criminal Code: Treatment and the Charter**

The *Criminal Code* of Canada also recognizes the logical link between detention for psychiatric reasons and compulsory treatment. If there were an absolute constitutional right to refuse involuntary treatment, section 672.58 of the *Criminal Code* would be unconstitutional. It permits a judge to order involuntary treatment for a person who is capable and refuses treatment, or is incapable and has an advance directive not to be treated or whose substitute decision-maker refuses to consent to treatment. The judge can order treatment for up to 60 days to restore fitness to stand trial.<sup>203</sup> Section 672.58 probably can be justified under section 1 of the *Charter*. After discussing the *Fleming v. Reid* decision of the Ontario Court of Appeal, which appeared to say that competent wishes must be considered for non-consensual treatment to be constitutionally valid, Tollefson and Starkman wrote:

But s. 672.58 of the *Criminal Code* provides no context for protecting the wishes of the accused or the decisions of a substitute. On the contrary s. 672.62(2) expressly provides for treatment “without the consent of the accused or a person who, according to the laws of the province where the disposition is made, is authorized to consent for the accused”. The *Criminal Code* provisions appear to be justified under s. 1 of the *Charter* by a competing social value, namely the need to determine the innocence or guilt of the accused within a reasonable time, while witnesses are still available and memories are fresh. This need could not be met without provision for treating the small number of unfit persons who do not wish to be treated.<sup>204</sup>

Being treated compulsorily to the point of not requiring detention under the *Mental Health Act* is arguably as worthy a societal goal as serving the needs of the justice system.

### **C. Obligation Under *Mental Health Act* to Provide Treatment**

In some *Mental Health Acts*, there is a duty to provide treatment. In the Saskatchewan *Mental Health Services Act*, the obligation is quite explicit:

. . . where a person is detained in an in-patient facility, the attending physician shall endeavor with all resources reasonably available in the facility to provide the person with care and treatment as a result of which the detention of the person in the facility will no longer be required.

<sup>202</sup> H.A. Kaiser, “Mental Disability Law” in J.G. Downie, T.A. Caulfield & C.M. Flood, eds., *Canadian Health Law and Policy*, 2nd ed. (Toronto: Butterworths, 1999) at 262.

<sup>203</sup> *Criminal Code*, R.S.C. 1985, c. C-46, s. 672.58.

<sup>204</sup> E.A. Tollefson & B. Starkman, *Mental Disorder in Criminal Proceedings* (Toronto: Carswell, 1993) at 79.

[In regard to community treatment orders,] the attending physician shall endeavour, with all resources reasonably available in the community, to provide the person who is the subject of the order with services so that the compulsory treatment or care and supervision of the person will no longer be required.<sup>205</sup>

Similarly, in the British Columbia *Mental Health Act*:

A director must ensure

- (a) that each patient admitted to the designated facility is provided with professional service, care and treatment appropriate to the patient's condition and appropriate to the function of the designated facility and, for those purposes, a director may sign consent to treatment forms. . . .<sup>206</sup>

How can these obligations to treat, to get the person well enough to be discharged from detention, be honoured if treatment can be refused?

#### **D. Obligation Under *Mental Health Act* to Terminate Detention**

Under all *Mental Health Acts* there is at least an implicit obligation to discharge patients from involuntary status as soon as is reasonable. The New Brunswick *Act* makes this clear. To authorize treatment without consent the tribunal must be:

... of the opinion that, without the treatment, the person would be detained as an involuntary patient with no reasonable prospect of discharge.<sup>207</sup>

Similarly the Saskatchewan Act obliges the treating physician to terminate the detention:

...the attending physician shall endeavor with all resources reasonably available in the facility to provide the person with the care and treatment as a result of which the detention of the person in the facility will no longer be required.<sup>208</sup>

If, because the legislation allows the detained patient or the substitute decision maker to refuse treatment, the physicians' therapeutic hands are tied behind their backs and they cannot fulfill their obligation to terminate the detention.

#### **E. MENTAL HEALTH ACTS THAT REQUIRE "NEED FOR TREATMENT" AS CONDITION OF CERTIFICATION**

Similar to the argument that where an Act places an obligation on a physician or director to provide services or treatment which would end the detention, how can treatment refusal be reconciled in Acts that are specifically for the purpose of providing treatment (*e.g.*, British Columbia, Saskatchewan, Manitoba, Nova Scotia and Newfoundland and Labrador)? In these jurisdictions, unless the person is in need of treatment, they cannot be admitted as an involuntary patient.

<sup>205</sup> *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1, ss. 27 and 24.7.

<sup>206</sup> R.S.B.C. 1996, c. 288, s. 8.

<sup>207</sup> *Mental Health Act*, R.S.N.B. 1973, c. M-10, s. 8.11(3)(d).

<sup>208</sup> *Mental Health Services Act*, s.s. 1984-85-86, c. M-13.1, s. 27.

## **F. Consent for Involuntary Admission Not Required**

For a voluntary patient, valid consent must be obtained for admission to hospital as well as for treatment. Without valid consent to admission, a number of civil wrongs occur. How is it that the consent of involuntary psychiatric patients is not required for admission but, in some jurisdictions is required for treatment? Involuntary admission which can detain a person for long periods is certainly as intrusive on rights and freedoms as treatment which liberates a person from detention.

## **G. Voluntary Patients Are Not “the Same” as Involuntary Patients**

It has been argued that the equality section of the Charter (section 15) requires that involuntary psychiatric patients have the same right as voluntary patients to refuse treatment. However, their situations are markedly different because involuntary patients cannot leave the hospital when they want to. Treatment refusal at one level has the same effect for a voluntary and an involuntary patient: both lose the therapeutic benefit and avoid the side effects of the treatment. However, the consequences of treatment refusal are dramatically different for the voluntary and the involuntary patient. While the untreated voluntary patient is free to leave the hospital, the untreated involuntary patient stays detained, losing a fundamental liberty right. The detention will continue indefinitely or until the symptoms improve without treatment (which rarely happens) sufficient for discharge from detention.

## **H. “Treatment Refuser Trap”**

When a hospital must act on the previously expressed competent wishes not to provide treatment, a tragic trap awaits the incapable patient who changes his mind and wants treatment. Take the case of a person in Sevels’ position (“caged” in a seclusion room for 404 days because of previously expressed wishes).<sup>209</sup> Assume that one day he changes his mind and pleads with the staff to give him anti-psychotic treatment. Since he continues to be incapable, the staff cannot act on his request to give the medication. The substitute decision-maker cannot honour the patient’s new request for treatment because the decision-maker is bound by the previously expressed competent wish not to be treated. Instead of being able to assist the person to liberate himself from seclusion and psychotic symptoms, the law has ensured that such a restriction continues indefinitely.

## **I. Potential for Unprofessional Conduct and Negligence**

For psychiatrists and nurses to have to watch a person like Mr. Sevels with treatable schizophrenia “caged and warehoused” for 404 days (because of the law) when the professional standard for effectively addressing his problem (anti-psychotic medication) is “immediately at hand”, must be extremely disquieting. Nurses must also be concerned about the rights of patients in wards where they are likely to be assaulted by patients who cannot be treated. Nurses are taken

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<sup>209</sup> *Sevels v. Cameron*, [1994] O.J. No. 2123 (Ont. Gen. Div.).

back to the days prior to medication when mechanical restraint and injuries to patients and nurses were common. A psychiatrist who “treated” a psychotic patient with seclusion for 404 or even 14 days without anti-psychotic medication would probably be liable for professional misconduct in a Canadian jurisdiction that did not allow treatment refusal. A suit for negligence would also be possible. It is beyond the scope of this book to debate the ethics of forcing physicians by law to do things they otherwise would not, which are contrary to standard medical practice and which inflict serious harm on their patient for no clinically sound reason. It cannot be countered that the physician or nurse can withdraw services if they feel that damaging a patient by providing mechanical restraint is unethical when treatment with medication is the accepted medical standard. Withdrawal of services is not possible because the patient is not voluntary. The state insists that the patient be detained in a hospital. The Hippocratic oath applies directly to physicians but also to other health care providers. The admonition to “do no harm” must be questioned when a psychiatrist is forced by the law to prescribe 404 days of seclusion instead of following the modern medical standard of medications to assist a person with schizophrenic symptoms. Few would dispute that. Keeping a person in seclusion for 404 days or more, and in another case, detained in a hospital untreated for nearly two years, is harmful to the patient and raises ethical dilemmas.

### **J. Numbers of Treatment Refusers**

It could be argued that the treatment refusal scenario painted above, and the logical and ethical conundrums that arise, happen rarely and therefore the suffering of the few is the price for preserving the “autonomy” of all involuntary psychiatric patients, despite the negative effects of psychosis and continued detention on real autonomy. While the majority of initial refusers do eventually agree to treatment, often because of the pressure of continued detention, this can take weeks or months. Some require a decision from a tribunal or court which can take months or years.<sup>210</sup>

Although there appear to be no Canadian studies of the number of refusers, U.S. studies show a rate of refusal in civil commitment ranging from 1-24 per cent, with the average refusal rate at approximately 10 per cent. With forensic populations, however, the rate of refusal is much higher, with ranges from a low of 11-13 per cent to a high of 75 per cent.<sup>211</sup> The conclusion is that there are not inconsequential numbers of people who refuse if that right is provided.

## **XI. OPTIONS AND RECOMMENDATIONS FOR TREATMENT AUTHORIZATION CRITERIA, PROCEDURES, REVIEWS AND APPEALS**

The fundamental questions in this area of law, policy and reform are: should an absolute treatment refusal right be recognized for involuntarily detained

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<sup>210</sup> R.L. O'Reilly, “Mental Health Legislation and the Right to Appropriate Treatment” (1998) 43 *Can. J. Psychiatry* 811-15.

<sup>211</sup> P.S. Appelbaum, *Almost a Revolution* (New York: Oxford University Press, 1994) at 134.



patients? This refusal can come from a capable patient or an incapable patient with a valid advance directive not to be treated or from the substitute decision-maker of an incapable patient. If treatment refusal is honoured, what should be done about the many serious harms and ethical dilemmas that flow from treatment refusal because patients must continue to be detained? If treatment refusal is to be overridden, what are the criteria and procedures that make clinical sense, promote dignity and conform with the Charter? This section discusses some principles to be considered in formulating the options and makes recommendations.

### **A. Principles of Treatment Authorization and Review (Clinical and Legal)**

The human needs perspective considers the following principles derived mainly from good clinical practice in the treatment and care of persons so ill as to be deemed by the state to require detention (and in some Acts, treatment) in a hospital. The criteria and procedures must:

- serve the best interests of involuntarily hospitalized patients;
- accord with the Charter;
- take into account the patient's wishes — both previously expressed capable wishes and present wishes including incapable wishes;
- take into account other relevant information for formulating an optimal treatment plan including information from records, relatives, significant others and other care providers;
- not significantly harm the patient (*e.g.*, not permit serious psychological or physical suffering or pain, physical harm to self or others, or unnecessary deprivation of liberty);
- be the least restrictive and intrusive option with due regard to effectiveness and efficiency;
- be timely, given that many involuntary hospitalizations are now measured in a few days or a few weeks; and
- take into consideration standards of medical practice for treating serious psychiatric illnesses.

### **B. Treatment Authorization and Purpose of the *Mental Health Act***

Whether a jurisdiction uses a state or private treatment authorization model, or uses best interests or capable wishes criteria, relates to the purpose of their *Mental Health Act*. It might be argued that in those jurisdictions where the purpose of the Act is to prevent dangerous behaviour through detention (*e.g.*, Ontario), where treatment is not mentioned either in the admission criteria or obligations of the hospital (the “quarantine” model), there is no need for the state to be involved in treatment authorization. Treatment arrangements are the same as for voluntary patients. However, in jurisdictions where providing

treatment is the primary purpose of the Act (e.g., British Columbia), the state does provide the authorization to treat since not to treat is contrary to the purpose of the Act. This purpose also influences the authorization criteria chosen. Provinces with legislation that has a treatment purpose could not adopt a model that allowed absolute treatment refusal as that would be incompatible with the purposes of the Act. They could, of course, adopt modified best interests models like Manitoba and Nova Scotia where the wishes of the patient must be considered.

## **XII. RECOMMENDATION: *MENTAL HEALTH TREATMENT ACT* (STANDARD AND CRITERIA FOR SUBSTITUTE DECISION-MAKERS)**

### **A. Same Standard for All Decision-Makers**

It is recommended that the standard used to make the decision to authorize or deny treatment be the same for any substitute decision-maker, be they private or state, at the initial level and on review or appeal. This will avoid the situation where, for example, Ontario legislation was struck down, in part, because the review board used a different standard than the substitute decision-maker.

### **B. Formulating Treatment Plan**

Whether a state or private decision-maker model is used, the same process for formulating a treatment plan to be presented to a decision-maker is recommended. This provision seeks to encourage the patient's involvement in the treatment formulation process and to consider both previous capable wishes and present wishes. It also encourages the inclusion of relevant information from informal and formal care providers and significant others in the patient's life in formulating the plan. The recommended wording is:

In developing the recommended treatment plan, the attending physician shall:

- (a) discuss with the patient any previously expressed capable wishes about treatment for the current condition and the patient's current capable or incapable wishes;
- (b) where appropriate, obtain additional information from family, records, significant others and others relevant to the development of the treatment plan;
- (c) formulate a treatment plan based upon the physician's assessment and information and opinion received, that is in accordance with good medical practice, and in the patient's best interests including that it is the least intrusive and least restrictive plan that will lead to release from involuntary status as soon as is reasonable;
- (d) discuss with the patient the formulated treatment plan and appropriately modify it; and
- (e) present the recommended treatment plan, with its rationale, to the person responsible for authorizing treatment.

### C. Guidelines (Criteria) for Decision-Maker

Whether the decision-maker is appointed by the state or is a private decision-maker, the following recommended guidelines should be used in arriving at the decision to authorize or not to authorize treatment:

In making the decision, the person responsible for authorizing treatment must weigh factors (a), (b) and (c) prior to making the decision on a modified best interest standard (d):

- (a) the patient's previously expressed wishes relevant to the patient's current condition;
- (b) the patient's current wishes whether capable or not;
- (c) the patient's best interests that include a consideration of the following:
  - (i) whether the mental condition of the person will be or is likely to be substantially improved by the treatment,
  - (ii) whether the mental condition of the person will improve or be likely to improve without the treatment,
  - (iii) whether the anticipated benefit from the treatment outweighs the risk of harm to the person,
  - (iv) whether the treatment is the least restrictive and least intrusive treatment, and
  - (v) whether, without the treatment, the person would continue to be detained as an involuntary patient for a longer period than with the treatment; and
- (d) the decision-maker must authorize treatment if the treatment is in the best interests of the patient, giving due weight to the patient's wishes but not to the extent that acceding to the wishes is likely to cause the patient or others harm, including longer detention than would be the case with the treatment plan recommended by the physician.
- (e) [As an alternative to (d) having similar effect but modeled on Manitoba and Nova Scotia] the decision-maker must authorize treatment (a) in accordance with the patient's capable previously expressed wishes applicable to the circumstances if these are known; or (b) in accordance with what the person believes to be in the patient's best interests if (i) the person has no knowledge of the patient's expressed wishes, or (ii) following the patient's expressed wishes would endanger the physical or mental health or safety of the patient or another person.

These recommendations combine a number of concepts, including those discussed in *Fleming v. Reid*<sup>212</sup> which emphasized that capable wishes should only be overridden if there are compelling reasons and that previously expressed wishes should be considered. The best interests elements outlined above are the compelling reasons in the case of an individual, especially considering the denial of liberty rights and the serious harms created if treatment is refused. The recommendation also incorporates elements of the Saskatchewan *Mental Health*

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<sup>212</sup> [1991] O.J. No. 1083, 4 O.R. (3d) 74 (Ont. C.A.).

*Services Act*<sup>213</sup> that requires the physician to discuss the treatment with the patient. This, together with consideration of any previously expressed wishes should provide for better treatment and promote the dignity of the patient. Because the patient's family and significant others frequently have considerable knowledge about what has and has not worked, they should be consulted as needed. Finally, the section on best interests is taken from the New Brunswick statute.

It is clear, however, that a previously expressed wishes model is not recommended, no matter how many caveats are added. Even if it could be demonstrated that a person had been fully competent and had foreseen all possible consequences at the time when they had expressed the wish to refuse treatment, that wish should not be binding. In circumstances where the state fulfils its responsibility to protect the individual and/or the rest of society by ordering compulsory detention, the state has a further responsibility to take reasonable steps to minimize the restrictiveness and duration of that detention. When this obligation conflicts with the patient's previously expressed wish, the state's response should achieve a balance between the conflicting demands. The patient's wish should be taken into account, but should not be absolutely binding.

#### **D. Decision-Maker: State or Private?**

The options used in Canada, at present, for a person who is to make the decision to consent to or refuse treatment include: state authorized decision-makers (treating physician, director of the psychiatric unit, or tribunal) and private decision-maker hierarchy commencing with a representative (legally appointed) of the patient, guardian, relatives, and public official (*e.g.*, public guardian/trustee) if no one else is available.

From a clinical perspective, authorizing of treatment by the state, as is the case with authorizing involuntary admissions, has a number of advantages. These include: the decision-maker is more knowledgeable and experienced in making treatment decisions than the average private decision-maker; delays in treatment and unnecessary detention while a substitute decision-maker is found are avoided; refusals are avoided; and the patient or others cannot cause delays through various reviews and appeals. Where the need for treatment is an admission requirement, the purpose of the legislation cannot be thwarted by a treatment refusal. On the other hand, the civil libertarian perspective might argue that hospitals or tribunals are likely to be biased. Perhaps the most likely bias on the part of the hospital is to treat so that an early discharge is possible because of the pressure for available beds. The civil libertarians would argue that compulsory treatment damages the patient's rights and bodily security by causing harmful side effects.

Two recommendations are provided in this section: a state model and a private model. We recommend the same method of formulating the treatment plan irrespective of whether it is presented to a state or private decision-maker.

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<sup>213</sup> S.S. 1984-85-86, c. M-13.1, s. 25(3).

The involvement of the patient and significant others is stressed in the development of the plan but, ultimately, it is the consideration of the best interests of the patient that must be paramount.

### ***1. Recommended State Model of Authorizing Treatment***

It is recommended that the state authorization decision-maker not be the treating physician, although that model is consistent with the human needs perspective and the purpose of a “treatment” Act. Instead, it is recommended that the decision be made by the director of the psychiatric unit, who is a physician and preferably a psychiatrist. This has the advantage of providing some distance between the recommender of treatment and the decision-maker. A psychiatrist is knowledgeable about the appropriateness of the proposed treatment, an important safeguard for patients. For example, if the proposal is to use a medication in an atypical manner, it is more likely to be questioned by a medical decision-maker than by a court or lay tribunal. Another advantage of an on-site decision-maker is access, so the decision can be rendered speedily in order that the patient not be detained longer than necessary. An on-site psychiatrist making these decisions is considerably less expensive than using a court or tribunal to make the same decision.

The recommended wording is:

The director of the psychiatric facility shall be the decision-maker with respect to the treatment plan recommended by the attending physician. Where the director is not a psychiatrist this function shall be delegated to a psychiatrist who is not the attending psychiatrist.

### ***2. Recommended Private Model of Authorizing Treatment***

The private model has the advantage that a substitute decision-maker may know the patient’s values and wishes, but the disadvantage that significant delays in alleviating suffering may result from the substitute decision-maker’s lack of knowledge or bias against psychiatric treatment, leading to the patient’s prolonged detention. It is recommended that a time limit be put on finding the substitute decision-maker. The recommended wording which also reflects some flexibility in the hierarchy of decision-makers, is:

- (i) Where a patient is incapable and requires psychiatric treatment, a substitute decision-maker such as a guardian, a person lawfully appointed by the patient when capable or a person who, in the opinion of the attending physician, is the most appropriate member of the patient’s family or other person who has a close relationship with the patient, may give consent.
- (ii) If a substitute decision-maker cannot be found within 72 hours of the initial attempt after reasonable diligence, treatment may be authorized by a public official designated for this purpose (*e.g.*, public trustee/guardian).

### XIII. TREATMENT AND REVIEW BOARDS AND COURT APPEALS

The major issue concerning reviews by a review board or appeals to the court is whether treatment that has been authorized stops if a treatment-related review or appeal is launched.

As we have seen in jurisdictions where treatment does not commence, or is stopped pending application for review or an appeal to the courts, the person can be detained without treatment for lengthy periods while all avenues of appeal are being exhausted (*e.g.*, nearly two years in one Ontario case and an average of 253 days in an Ontario study)<sup>214</sup>. Ontario has passed amendments which may make it easier to terminate treatment refusal because the treating health care professional can now ask the board to depart from a wish to refuse treatment whereas that, previously, only could be done by a substitute decision-maker.<sup>215</sup> The review process also should be speeded up because now the board can consider a number of treatment related issues simultaneously, rather than in separate hearings.<sup>216</sup> However, lengthy treatment delays or absolute refusal, with resulting lengthy involuntary detention, are still possible under Ontario legislation. Manitoba similarly stops treatment pending a court appeal.<sup>217</sup>

From a clinical and humanitarian point of view, and a Charter point of view, such an unnecessary deprivation of physical and psychological liberty (in the case of a deluded patient) and continuation of suffering is of great concern. This is especially true because a patient deciding to apply for review or seek an appeal, unlike a person making a treatment decision, does not have to be capable of making a decision to exercise such a right. In fact, the nature of paranoid delusions often propel a person into a litigious mode of thinking. For these reasons, treatment, once authorized, should continue until the review or appeal process is concluded. The Nova Scotia Act recognizes this issue: "... the decision of the Review Board takes effect immediately unless the Court of Appeal grants a stay of any order made pursuant to this Act where, in its discretion, it deems fit".<sup>218</sup>

#### A. Recommendation: *Mental Health Treatment Act* (Treatment Continues While Under Review or Appeal)

The recommended wording is:

Following the approval of treatment or incapability by the appropriate decision-maker, the treatment shall continue pending a review board hearing or appeal to the courts.

<sup>214</sup> R.L. O'Reilly, "Mental Health Legislation and the Right to Appropriate Treatment" (1998) 47 Can. J. Psychiatry 811-15; M. Kelly *et al.*, "Treatment Delays for Involuntary Psychiatric Patients Associated with Reviews of Treatment Capacity" (2002) 47 Can. J. Psychiatry 181-85.

<sup>215</sup> *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 36(1)(b).

<sup>216</sup> *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 37.1.

<sup>217</sup> *Mental Health Act*, C.C.S.M. c. M110, s. 30(6).

<sup>218</sup> *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42, s. 79(4).

An alternative recommendation, which allows for one level of review by an independent tribunal before treatment is started when treatment has been refused is:

Following the approval of treatment or incapability by a review board, the treatment shall continue pending an appeal to the court unless the court grants a stay.

#### XIV. AUTHORIZATION OF SPECIAL TREATMENTS

Most *Mental Health Acts* in Canada make no reference to “special treatments” including psychosurgery and ECT. However, psychosurgery is defined in Ontario, Saskatchewan, Alberta and the Yukon. Saskatchewan and Ontario prohibit psychosurgery for an incapable involuntary patient. Alberta requires the patient’s consent and a review board for psychosurgery.<sup>219</sup> This means that an incapable patient cannot be given psychosurgery. Psychosurgery may be carried out in the Yukon provided that the substitute decision-maker and the review board approve.<sup>220</sup> References to psychosurgery, while of potential significance, refer to a practice that stopped over 50 years ago in Canada. ECT continues to be a controversial form of treatment despite its scientifically demonstrated safety and efficacy. An effort to equate ECT with psychosurgery and, thus, effectively ban its use under the Ontario *Mental Health Act* was not successful in a court case in Ontario.<sup>221</sup>

Most provinces authorize ECT in the same manner as medications. A case in Ontario argued that the Consent and Capacity Board did not have the authority to authorize ECT, but the court found otherwise.<sup>222</sup> Saskatchewan has a procedure whereby ECT is designated as a special treatment under the regulations. This requires two psychiatrists to independently examine the patient, give consideration to the views of the patient and the nearest relative, and provide notice to the patient, nearest relative and official representative before ECT may be administered.<sup>223</sup>

In New Brunswick, a patient or any other person may apply to the review board where they are of the opinion that the treatment is not “routine medical treatment” as authorized by the tribunal or “specified psychiatric treatment” as authorized by the review board to determine if the treatment being given is the treatment authorized.<sup>224</sup> The Yukon is unique in requiring the review board’s approval for a chemotherapy regime lasting longer than three months.<sup>225</sup>

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<sup>219</sup> *Mental Health Act*, R.S.A. 2000, c. M-13, s. 29(5).

<sup>220</sup> *Mental Health Act*, R.S.Y. 2002, c. 150, s. 21(4).

<sup>221</sup> *T. v. Ontario (Western Reg Board of Review)*, [1983] O.J. No. 3249, 44 O.R. (2d) 153, 3 D.L.R. (4th) 442 (Ont. H.C.J.).

<sup>222</sup> *M. (A.) v. Benes*, [1998] O.J. No. 4333, 166 D.L.R. (4th) 658 (Ont. Gen. Div.).

<sup>223</sup> *Mental Health Services Regulations*, R.R.S. c. M-13.1, Reg. 1, s. 14.

<sup>224</sup> *Mental Health Act*, R.S.N.B. 1973, c. M-10, s. 31.1(1).

<sup>225</sup> *Mental Health Act*, R.S.Y. 2002, c. 150, s. 21(4).

## XV. CHARTER CHALLENGE — TREATMENT REFUSAL FOR INVOLUNTARY PATIENTS

This section addresses a central matter underlying almost every issue in this chapter. A number of Charter court cases clearly show that laws that permit admission without consent (involuntarily) of a person with a serious harmful mental illness, are constitutional.<sup>226</sup> Of course without the *Mental Health Act* admissions without consent would be illegal. A question that has not received the same judicial attention is whether or not legislation that allows a patient admitted without consent to be treated without consent conforms to the Charter. This question is the subject of discussion in this section.

A finding that the Charter does not allow treatment without consent for patients detained without consent would have serious implications for the law in all jurisdictions that do not allow an absolute right of treatment refusal (British Columbia, Saskatchewan, Newfoundland and Labrador). Both Alberta and New Brunswick, which now allow a tribunal to overturn a refusal that is not in the person's best interests, would have to change their legislation. Even provinces that honour previously expressed valid wishes not to be treated, except where that is likely to seriously harm the person or others, would have to respect such harmful wishes (Manitoba, Nova Scotia). Finding treatment without consent to be wholly unconstitutional would also have implications for the *Criminal Code* which allows treatment without consent to restore fitness to stand trial. However, if that becomes unconstitutional then people may refuse treatment, never become fit to stand trial, never be tried and stay incarcerated indefinitely.

The Charter sections most likely to be used in a challenge to any restriction of the right of an involuntary psychiatric patient, or a person on the patient's behalf, to refuse treatment for an involuntary psychiatric patient that is different from a non-psychiatric medical patient (who can refuse consent for life saving treatments) are section 7 (Life, Liberty and Security of Person), section 15 (Equality) and section 12 (Cruel and Unusual Punishment or Treatment). Section 2 on freedom of thought may also be argued. If any violations of a particular section are found they may or may not be justified in our free and democratic country under section 1 (Override).

*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.*

As noted above, courts have found that even though admission without consent under a *Mental Health Act* does deprive a person of liberty under section 7, that deprivation occurs in accordance with the principles of fundamental justice so that the Charter is not violated. However, it is not just the procedural aspects of committal (e.g., clearly defined criteria, reviews, notice, two examiners) but also

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<sup>226</sup> *McCorkell v. Riverview Hospital*, [1993] B.C.J. No. 1518, [1993] 8 W.W.R. 169, 81 B.C.L.R. (2d) 273 (B.C.S.C.); *Bobbie v. Health Sciences Centre*, [1988] M.J. No. 485, [1989] 2 W.W.R. 153, 56 Man. R. (2d) 208, 49 C.R.R. 376 (Man. Q.B.); *Starnaman v. Penetanguishene Mental Health Centre*, [1994] O.J. 1958 (Ont. Gen. Div.), affd [1995] O.J. No. 2130, 24 O.R. (3d) 701, 83 O.A.C. 95, 100 C.C.C. (3d) 190 (Ont. C.A.).



the substantive reason for the particular restriction of liberty that comprise “fundamental justice”. As the British Columbia Superior Court commentary states “...courts are now required whenever such a [Charter] question arises to examine the content of legislation in order to ensure a proper balance between the interests of the state and the interests of individuals or groups in society”.<sup>227</sup> There are also competing values within section 7. While the *Fleming v Reid* court stressed the damage to security of the person done by non-consensual treatment the court failed to acknowledge that without treatment, the liberty right was compromised. The outcome of a Charter challenge to a *Mental Health Act* that permits treatment refusals to be overridden will likely turn on the Act’s pressing and substantial objective (who will it benefit or harm, what will it achieve, what happens if it is not allowed) and on the procedural aspects of how treatment is authorized, judged against the objective.

### **A. Pressing and Substantial Objective of Treatment Without Consent for Involuntary Patients**

The pressing and substantial objective of laws allowing treatment without consent for psychiatric patients detained without consent, under a *Mental Health Act*, is to provide treatment to help them recover from the illness that is responsible for their detention so that their Charter liberty right is restored. Without treatment, compulsory if necessary, people will continue to suffer and remain detained for long periods causing significant problems for themselves, fellow patients, families, treatment providers and society.

The evidence that can be adduced to support the contention that the pressing objective of the law is to provide standard psychiatric treatment to relieve suffering and hasten liberty, comes from court findings, various provinces’ *Mental Health Acts*, and legal and other commentary. (This discussion will be succinct as the detail has been presented earlier in this chapter.)

The Manitoba Court of Appeal in a Charter challenge wrote:

...The objective of the compulsory admission provisions of the Act is a sufficiently significant one; the objective is a socially desirable one, indeed, a necessary one. The community has an interest in seeing that mentally disordered persons have appropriate care and treatment, in some cases, *compulsory* treatment.<sup>228</sup>

In a British Columbia Charter challenge a Supreme Court Justice wrote:

<sup>227</sup> British Columbia Superior Courts Home Page, “A Compendium of Law and Judges: The *Canadian Charter of Rights and Freedoms*”, June 18, 1999, online: < [http://www.courts.gov.bc.ca/legal\\_compendium/section\\_7.asp](http://www.courts.gov.bc.ca/legal_compendium/section_7.asp)>, see s. 7(5); see also section III. C, “What Is the Charter” in Chapter 3 of this book.

<sup>228</sup> *Thwaites v. Health Sciences Centre Psychiatric Facility*, [1988] M.J. No. 107, 48 D.L.R. (4th) 338, [1988] 3 W.W.R. 217 at 229, 51 Man. R. (2d) 196 (*sub nom. Thwaites v. Health Sciences Centre*), 40 C.R.R. 326 (Man. C.A.) (emphasis added).

The context of the purpose of the Act and Regulations is detention of persons only for the purpose of treatment.<sup>229</sup>

An Alberta court, in a case involving a competent involuntary patient ordered to take medications by the review board, stated “Nonetheless, for the time remaining until a final decision can be reached with respect to the Applicant’s constitutional rights which could encompass many more months, I conclude that it is not of benefit to anyone to keep her in a mental health facility without any treatment.”<sup>230</sup>

Given that the societal purpose of *Mental Health Acts* is well established, what are the provisions in an Act that bear on the pressing and substantial objective of authorizing treatment without consent? A number of Acts have specific and necessary requirements in the committal criterion that allows involuntary admission only if people are “in need of treatment”. If treatment cannot be provided because a person or their substitute decision-maker refuses then the purpose of the Act is thwarted. A number of Acts also require the treating physician to provide treatment to shorten the period of detention. Again without treatment this obligation placed on the service provider cannot be fulfilled. In this vein the Law Reform Commission of Saskatchewan wrote:

Civil commitment exists to provide treatment for seriously disturbed patients. If treatment cannot be provided by the facility to which the patient has been committed, there is no jurisdiction for continuing the committal. Logically, therefore, authority to direct hospitalization without consent of the patient must entail authority of some form of treatment without consent.<sup>231</sup>

Rozovsky and Rozovsky in their Canadian consent law text put the logic for treating those committed this way:

This creates a problem in that an individual is placed against his will in a hospital which has the main purpose of treating in order to affect a cure to remove the reason for the person being committed. By allowing the person to refuse treatment, the rationale for the committal is thwarted.<sup>232</sup>

It should also be noted that British Commonwealth democratic jurisdictions such as the U.K., Australia and New Zealand find it pressing and necessary not to allow refusal of the treatment required to restore the liberty and address the symptoms of an involuntarily detained patient.

The patients admitted without consent are generally the most ill of all the people with mental health diagnoses. They have met the involuntary admission criteria (see discussion on means chosen) and most have illnesses that do not spontaneously (without treatment) recover. For these people the pressing and

<sup>229</sup> *Mullins v. Levy*, [2005] B.C.J. No. 1878 at para. 214, 2005 BCSC 1217 (B.C.S.C.). See also *British Columbia (Forensic Psychiatric Services Commission) v. British Columbia (Mental Health Act Review Panel)*, [2001] B.C.J. No. 2518 at para. 42, 2001 BCSC 1658 (B.C.S.C.).

<sup>230</sup> *Rogerson v. Alberta Hospital (Edmonton)*, [1999] A.J. No. 598 at para. 86, 1999 ABQB 412 (Alta. Q.B.).

<sup>231</sup> Saskatchewan Law Reform Commission, “Proposals for a Compulsory Mental Health Care Act” (1985) at 7.

<sup>232</sup> L.E. Rozovsky & F.A. Rozovsky, *The Canadian Law of Consent to Treatment* (Toronto: Butterworths, 1990) at 44, 45.

substantial objective of authorizing treatment against their will if necessary can also be demonstrated by what happens when treatment is withheld. Evidence has been reviewed above that treatment refusal results in the following harms: increased patient suffering, increased use of restraints and seclusion, much longer detention in hospital, poorer prognosis, increased assaults on other patients and nurses and extra costs for longer stays and increased supervision. In addition, an incapable patient with a pre-expressed wish not to be treated cannot ask to be treated because the previous competent wish is binding (treatment refuser trap).

Not allowing treatment affects more than the patient and this would be taken into account by a court in deciding if the objective was pressing and substantial. Families must wait much longer for their loved ones to get better and be released. Physicians and nurses have the moral dilemma of providing substandard care, for example seclusion instead of medication, that if it were not for the law they would be disciplined by their professional body. Governments must fund hospitals for providing substandard care for long periods which denies many urgent cases access to the beds.

## **B. Fundamental Justice: Means Chosen to Meet the Objective — Substantive, Procedural**

To justify a restriction of liberty or security of the person not only must the objective be in accord with the principles of fundamental justice but the means for achieving that objective must also be. The means chosen that restrict liberty or security of the person must show a rational connection with the objective. The means chosen must also infringe “as little as is reasonably possible” on the restriction of liberty or security. There must be proportionality between the effects of the measures to restrict liberty or security of the person and the objective. In addition, the “due process” aspects of the law such as procedures, reviews and appeals must be appropriate and proportional to the objectives of the law.<sup>233</sup> This section will first discuss the means chosen to address the detention and then the procedural aspects.

### **1. Fundamental Justice: Substantive Means Chosen — Psychiatric Treatment**

#### ***(a) Is There a Rational Connection Between Compulsory Treatment and Restoring Liberty?***

Yes. The illnesses (*e.g.*, bipolar, schizophrenia) that most often cause harmful behaviour that lead to admission without consent are brain illnesses. It therefore should be no surprise to find that the scientifically proven method of treating these disorders is by drugs that improve brain functioning. Most people have their liberty restored with these drugs in about one month. If these treatments

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<sup>233</sup> Note: this material is adapted from the *Oakes* test. This applies to section 1. However, it also provides a useful guide to decide whether a restrictive provision likely meets the fundamental justice requirement of section 7. See Chapter 3, section III. C.3, “Charter Challenges”.

cannot be provided to people who are involuntarily detained they will not have their symptoms ameliorated and will stay detained indefinitely. Prior to the development of these drugs hospital stays were measured in months and years. In the acute stage of illness there are no alternatives to psychiatric treatments for treating psychotic symptoms. Non drug approaches including shackling and isolation are often necessary to protect the patient and others when drug treatment is not provided. See Chapter 4 for a detailed discussion of the effects and side effects of medication. Thus there is a rational connection between requiring a person to take these medications in their best interests and the pressing and substantial objective of helping them recover and being released from detention.

***(b) Is Security of the Person Interfered with as Little as Reasonably Possible?***

Yes. Since there are no scientifically proven methods of reducing the symptoms of severe mental illness and restoring liberty for involuntary patients, other than by psychiatric treatment, the security of the person is interfered with as little as possible by being required to take medication. The very great majority of people who are required to take medication without their consent are not physically forced. An analogy of compulsory car seat belt use is apposite: most people put their seat belts on and are not forced to do so, even people who do not believe in them.

In the relatively rare circumstance where a person must be physically forced to take medication this is usually for a short time before the person agrees to take it. The majority of compulsory medication is taken orally with a small amount by injection, although some patients prefer the convenience of injections. If the person will not take the medication in an acute phase, the alternative, to protect the patient or others, is sometimes shackling or isolation with the risk of injuries to both the patient and staff. Both impair the right to liberty and security of the person. The security of the person in the sense of being able to exercise ones freedom is interfered with less by having to take a licensed oral medication prescribed and monitored by a psychiatrist than by being detained for long periods and restrained and isolated. Without treatment the liberty right is infringed and other harms listed above are the result.

***(c) Is There Proportionality between the Deleterious and Salutary Effects of the Measure (Compulsory Psychiatric Treatment)?***

Yes. Psychiatric medications have all been licensed by the Government of Canada and proven in many scientific studies to be effective in reducing the symptoms that lead to involuntary hospitalization (psychosis, aggression caused by the illness, *etc.*). Medications ordinarily lead to a reasonably short length of involuntary detention, compared with treatment refusal, and many people gain insight into the fact that they have a treatable mental disorder.

Licensing of these drugs, indeed any drug, by the Government of Canada also means that they have an acceptable risk of deleterious effects. The deleterious effects of psychiatric treatment without consent include the same deleterious

effects of medications which millions of people take throughout the world voluntarily. There are side effects some very serious but most minor and short term. As Dr. Liddle in Chapter 4 concludes: "However, in most instances where the illness leads to problems severe enough to warrant compulsory detention, the risks of not treating with medication outweigh the risks of side effects."<sup>234</sup> It might be thought that patients compelled to take these medications would feel strongly that their security of person had been violated. Some of course do but studies that have sought the opinions of patients, who have been treated compulsorily under the *Mental Health Act*, after the period of acute treatment, reveal that the majority of the patients consider in retrospect that the medication was helpful.<sup>235</sup>

***(d) Is There Proportionality between the Deleterious Effects of the Measures which Are Responsible for Limiting the Rights and Freedoms in Question and the Objective?***

Yes. The above discussion has shown that psychiatric treatment is the only known means for achieving the objective of reducing symptoms and restoring liberty and freedom of the person. If psychiatric treatment had crippling side effects that were worse than being detained for years then it might be concluded that the price to gain freedom was too high. However, all the evidence is that although there are side effects the very great majority of patients who take these medications do have their liberty restored, their mental state and functioning in society improved with relatively minimal side effects. It is concluded that there is a reasonable proportionality between the means chosen, compulsory psychiatric treatment, and the objective of restoring liberty and security of the person through treating symptoms of the illness.

## **2. Fundamental Justice: Procedural Means Chosen**

It has been shown that psychiatric treatment is the substantive means proportional to the objective of restoring the freedom of involuntarily detained patients. This section examines how treatment is authorized for such patients. First, the procedures for becoming an involuntary patient are briefly recapped since these have been accepted by the courts as fulfilling the requirements of fundamental justice for that purpose. Second, the procedures for how treatment is authorized will be discussed. This is a truncated discussion because the details of the various approaches have been presented above.

People subject to treatment without consent have been admitted without consent. Admission without consent is only allowed by legislation if the person is not suitable as a voluntary psychiatric patient and meets the definition of mental disorder (in a number of jurisdictions this includes a need for psychiatric

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<sup>234</sup> Chapter 4, section IV.A, "Anti-Psychotics".

<sup>235</sup> Treatment Advocacy Centre, "The Effects of Involuntary Medication on Individuals with Schizophrenia and Manic-Depressive Illness" (2006), online:<<http://www.psychlaws.org/BriefingPapers/BP2.htm>>. W.M. Greenberg *et al.*, "Patients' Attitudes Toward Having Been Forcibly Medicated" (1996) 24 Bulletin of the American Academy of Psychiatry and the Law 513-24.

treatment), is likely to cause serious harm to self or others or be likely to significantly deteriorate and be in need of psychiatric treatment. In some jurisdictions the person must also be incapable of making an admission or treatment decision. Thus it is a relatively small well defined group of people with mental disorders who meet multiple criteria who become subject to treatment without consent and then only with a number of procedural protections.

On the procedures, which have been found to meet Charter requirements when it comes to admission without consent, the person receives at least two independent examinations, including interviews, from qualified physicians. In these interviews the person usually expresses their opinion on whether they want to be admitted as a voluntary patient and whether they accept psychiatric treatment or demonstrate that they are not capable of making these decisions. Thus in the admission examination process people do have an opportunity and usually do express their preferences. Other procedural protections such as notice, right to a lawyer, renewal certificates and review tribunals make up part of the fundamental justice protections for persons whose treatment is approved by others. The substantive and procedural protections for persons subject to treatment without consent are logically and legislatively linked to the admission without consent criteria and procedures. This is specially so in jurisdictions which explicitly recognize that the reason for involuntary admission is to receive psychiatric treatment that it is not possible to provide with consent.

Various types of reviews and appeals are available in different jurisdictions including second medical opinions, review boards for discharge or capability, courts. These are the same types of protections found to be constitutional in involuntary admission schemes.

*Section 15. (1) 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.*

It may be alleged that jurisdictions that do not allow or override treatment refusal for involuntary patients violate “the right to equal protection and equal benefit of the law without discrimination, based on ... mental disability” (section 15). It can be argued that these two groups, voluntary and involuntary psychiatric patients, are not equal under the law. If a voluntary patient does not receive treatment they may discharge themselves at any time. In stark contrast an involuntary patient who does not receive treatment must be detained by law indefinitely. The only way a detained patient can receive the protection of the Charter rights of liberty and autonomy, that a voluntary patient enjoys, is to receive treatment, compulsory if necessary, which restores liberty and autonomy.

*Section 12. Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.*

A judge in Ontario, because of Ontario law, could not authorize treatment for a man who had to be isolated in a seclusion room for over 404 days. It was found

that had this person with schizophrenia been treated with standard anti-psychotic medication this would not have occurred. The judge said of the Ontario law "... I express the view that it surely cannot be the intended result of the *Charter of Rights and Freedoms* that people entrapped in the cage of their mental illness and ... be for prolonged periods caged and warehoused in mental health facilities where the key to their necessary and involuntary seclusion is available with relatively little likelihood of substantial risk". Secluding someone for over 404 days must now be considered to be cruel and unusual treatment, and contrary to the Charter. Prior to the development of anti-psychotic medications in the 1950s seclusion was not unusual but today a physician who prescribed 404 days of seclusion to "treat" a person with schizophrenia would be guilty of unprofessional conduct, in jurisdictions where treatment refusal is not permitted. Other examples of cruel and unusual treatment resulting from unnecessary lengthy detention arising from Ontario's law that allows treatment refusal for patients who have been admitted without consent are referred to above.

*Section 2. Everyone has the following fundamental freedoms ... (b) freedom of thought. ....*

Many people with acute schizophrenia or mania do not have freedom of thought. Their thoughts, be they delusions or hallucinations, are driven by brain dysfunction. Delusions and hallucinations can cause persons to harm themselves and harm others. A number of people with these mental disorders, when untreated, cannot think rationally. The only way to assist these people to have freedom of thought (not interfered with by delusions and hallucinations, rational thought) is by psychiatric treatment. It is argued that a law that requires a person to stay detained because of a disorder of thought, then deprives that person of the treatment that is likely to bring the detention to an end, violates section 2 of the Charter.

*Section 1. 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.*

If any of the Charter sections are found to be violated by provisions that allow for persons with a mental disorder who have been detained in hospital without their consent to be treated without their consent, then they may be saved by section 1. The *Oakes* test is used and its principles have been used here in the analysis of section 7. Regarding what is demonstrably justified in a free and democratic society, it is noteworthy that New Zealand, the six Australian states and the three U.K. jurisdictions do not allow an involuntary patient to refuse the treatment required to restore their freedom.

