

SPECIAL ISSUE

AN EXCHANGE OF VIEWS

ON

*WHAT CONSTITUTES REASONABLE REVIEW OF
TREATMENT CAPACITY*

Capacity Reviews -Clinical and Liberty Outcomes 1

Richard O'Reilly, M.B., F.R.C.P.C, Robert Solomon, LL.B., LL.M., John Gray, Ph.D.

Capacity, Rights and Interests 10

Stephen A. State Ph.D.

Response to "Capacity, Rights and Interests"..... 14

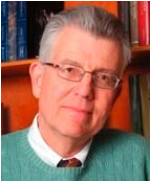
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Clinical and Liberty Outcomes



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Abstract

Objective: To determine how often Ontario courts have overturned a review board's confirmation of a physician's finding of treatment incapacity or otherwise upheld a patient's right to refuse treatment and determine what happened to these patients after the court ruling.

Method: We used LexisNexis Quicklaw to identify all reported cases in which a psychiatric patient's treatment capacity or prior capable wishes (advance directives) to refuse treatment were upheld by an Ontario court. We then used information available in the public domain to determine what happened to the patient after the court ruling.

Results: We identified 6 cases during the 15 year study period. The courts overturned a confirmation of treatment incapacity in only 2 cases. In 4 cases the court held that the person could not be treated because, while capable, they had previously expressed a wish not to be treated. Only 1 patient was subsequently discharged from hospital without treatment. Despite an earlier court decision upholding their right to refuse treatment, 4 patients were treated over their objections. These patients were detained untreated in hospital for lengthy periods of time and only became well enough to be discharged when treatment was given. One patient has remained in hospital untreated for over 25 years.

Conclusions: In its current form, the Ontario legislation fails to protect the liberty and health interests of involuntary hospitalized psychiatric patients.

Clinical Implications: It is very rare for a court to overturn a review board's decision on treatment capacity. Most committed patients who challenge findings of treatment incapacity will not become well enough to be released without psychotropic medication. Despite a court ruling upholding a patient's refusal of consent, many of these patients are eventually treated with psychotropic medication. Statutory and common law must adopt a nuanced approach that recognizes the need to balance the sometimes conflicting interests of involuntary psychiatric patients.

Limitation: There was limited information in the public domain for some cases. We were not able to systematically assess other important outcomes of treatment refusal such as seclusion and assaults on staff or other patients.

Key words: Involuntary hospitalization, civil commitment, treatment capacity, courts, treatment delay, treatment refusal, Ontario.

Background

Starson v. Swayze is the only case involving treatment capacity that has been heard by the Supreme Court of Canada¹. In June 2003, a majority of the Supreme Court of Canada (SCC) held that Scott Jeffery Starson, or Professor Starson as he insisted on being called, was capable of refusing recommended psychiatric treatment when he was admitted to an Ontario hospital as an involuntary patient in 1998. Various academic opinions have been expressed about the decision's relevance to the practice of psychiatry in other Canadian provinces. Sklar has suggested that the *Starson* decision has 2 important implications: first, that the right of a capable committed patient to refuse treatment is likely to be upheld in any future cases heard by the SCC; and second, that a patient's best interest should be viewed as irrelevant when determining treatment capacity². Others see *Starson* as a limited review of the Ontario Health Care Consent Act, 1996³ (HCCA), which therefore did not set a precedent outside of Ontario⁴. While there has been considerable academic analysis of *Starson*, many lawyers and psychiatrists are unaware that Starson was treated 2 years after the Supreme Court's ruling⁵.

In the months leading up to the initiation of treatment, Starson had stopped eating based on delusional beliefs. When his weight and hydration deteriorated to a point where his life was at risk, Starson was again found to be incapable by a physician. Starson challenged this finding, but it was upheld by an independent tribunal, the Consent and Capacity Board (CCB), and treatment was started⁶. With treatment, Starson regained his physical health and his psychotic symptoms improved sufficiently so that, for the first time since his admission in 1998, he was able to leave hospital. Starson's case has been hailed as a libertarian victory⁷. However, had antipsychotic treatment been started in 1998, it is reasonable to assume that Starson would have regained his freedom at least 6 years earlier.

Starson's life would have been very different had he been admitted in most other Canadian jurisdictions. In Ontario, a person who is involuntarily hospitalized can refuse recommended treatment⁸. In contrast committed patients cannot refuse treatment in 3 provinces: British Columbia⁹, Saskatchewan¹⁰ and Newfoundland and Labrador¹¹. Other provinces allow a patient's competent refusal to be overridden by a tribunal when that is in the patient's best interest – see for example, Alberta¹² and New Brunswick¹³.

When a patient in Ontario is assessed as incapable of consenting to treatment, the patient can apply to the CCB for a review of that finding. The patient can also appeal any unfavourable decision from the CCB to the courts. Importantly, the HCCA states that treatment cannot start until the application to the CCB has been decided and any further appeal to the courts has been withdrawn or resolved¹⁴.

In a previous study, we found that the CCB overturned just 1.5% of physicians' findings of treatment incapacity at 2 psychiatric hospitals in Ontario¹⁵. In the 10 year period of that study, 15 patients from the 2 hospitals appealed the CCB's decision to the courts. The finding of incapacity

was upheld in all of the cases in which the courts resolved the issue. We calculated that the average delay in initiating treatment for patients who appealed to the courts was 253 days.

We believe that a delay of more than 8 months to decide a treatment capacity challenge is an unacceptable deprivation of liberty. In addition to deprivation of liberty, research has shown numerous other negative outcomes associated with non treatment of committed patients: increased use of seclusion and restraint further limiting freedom^{16, 17, 18, 19, 20, 21}, increased frequency of physical assaults on other patients and staff^{22, 16, 17, 23}, worsening of the long term prognosis^{24, 25}, disruption of the therapeutic milieu on hospital wards affecting other patients¹⁸, negative effect on the therapeutic relationship^{26, 27}, use of scarce inpatient beds preventing other patients accessing treatment, and substantial legal costs which result in the diversion of funds from clinical care.

The fact that the courts did not overturn a CCB's confirmation of treatment incapacity in any case in our initial study¹⁵, suggests that this rarely happens. However, that study was limited to 2 hospitals and the associated local courts. The current study was undertaken to determine the number of cases in all of Ontario, where the courts have overturned a CCB confirmation of a finding of treatment incapacity or otherwise upheld a patient's right to refuse treatment.

The knowledge that Starson was eventually treated, despite the SCC's decision that he was capable when first admitted in 1998, led us to investigate what happened to other involuntary patients in Ontario when courts upheld an involuntary patient's right to refuse treatment.

Method

We used LexisNexis Quicklaw to identify all reported cases in which a psychiatric patient's treatment capacity or prior capable wishes (advance directives) were addressed by an Ontario court. The study encompassed the 15 years from January 1st, 1990 to December 31st, 2004. At the outset of our 15 year study period, the treatment capacity of psychiatric patients and related issues were governed by the predecessor to the current Ontario Mental Health Act²⁸. As of April 3, 1995, these issues were governed by the Consent to Treatment Act, 1992²⁹. However, that Act was repealed and replaced by the HCCA³ in 1996. Consequently, it was necessary to search the relevant sections of these 3 Acts in the Quicklaw database. The cases found in this search were reviewed to identify any that met our study's parameters. A list of such cases was compiled and sent to several key lawyers and forensic psychiatrists in Ontario who were asked if they knew of any relevant cases that were not included in our list.

We knew from the *Starson* case that there was likely to be information in the public domain concerning the psychiatric history of some of these patients, both prior to and following the court proceedings. Consequently, we searched for any reference to the identified patients in the records of the "Review Boards" under the Mental Health Act, the "Consent and Capacity Review Boards" under the Consent to Treatment Act, the "Consent and Capacity Boards" under the

HCCA, and the Ontario Criminal Review Boards. We also attempted to locate all public documents pertaining to these patients, even when the source predated 1990. Media reports were identified using Google. A standardized protocol was developed for extracting and recording information from these legal and media reports in order to compile a comprehensive account of the patient's demographic profile, psychiatric history, and criminal and mental health law involvement.

Results

We identified 6 cases over the 15 year study period through the Quicklaw search. Review by the key stakeholders did not produce any additional cases. The courts overturned a confirmation of treatment incapacity by the CCB or its predecessors in only 2 cases *Starson*¹ and *Neto v. Kluckach*³⁰. In 4 cases, *Fleming v. Reid*³¹, *Fleming v. Gallagher* (whose case was heard together with Reid's at the Court of Appeal), *Sevels v. Cameron*³², and *Conway v. Jacques*³³, the courts held that the patients could not be treated because they had previously expressed a wish, while capable, not to be treated.

In other publications, we have provided a detailed account of these patients' clinical and legal histories based on the information available in the public domain^{5, 34}. In this report, we will summarize the main points of these cases.

The primary diagnosis for Reid and Gallagher was schizophrenia. Both had also been noted to have antisocial personality disorder and substance abuse. Sevels had also been diagnosed with schizophrenia. Starson was initially diagnosed with bipolar disorder, but the diagnosis was later changed to schizoaffective disorder. Conway was diagnosed with a psychotic disorder not otherwise specified, and an associated complex personality disorder characterized by borderline, narcissistic and paranoid traits. Neto was diagnosed with a bipolar disorder.

Four patients, Starson, Sevels, Reid, and Gallagher, were treated over their objections, despite an earlier court decision upholding their right to refuse treatment. It was only when the patients' situations became dehumanizing or life threatening that their capacity or prior capable wish was reassessed³⁴. All 4 patients were detained untreated for prolonged periods, ranging from more than 5 years for Sevels to approximately 10 years for Gallagher. During their hospitalizations, Sevels, Reid and Gallagher were subject to frequent periods of involuntary seclusion. Court records show that by the time the court heard Sevels' case, he had been in seclusion for 404 consecutive days. As had been predicted by their psychiatrists, the mental health of these 4 patients deteriorated without the recommended medications.

The clinical history of each of these patients, prior to the court ruling, indicated that they had an illness that was responsive to the proposed medications. Therefore, it is not surprising that the clinical condition of all 4 patients improved when antipsychotic medication was eventually started. All 4 were eventually discharged from hospital with treatment.

Neto was the only patient who was able to secure her release from hospital without being required to take the recommended psychotropic medications. Neto's situation differed from that of the other 5 patients in several ways. She had a bipolar disorder, whereas the others had a primary psychotic disorder. Neto had apparently taken antipsychotic medication with few exceptions, since first diagnosed as a teenager. Moreover, Neto had been discharged from hospital by the time her case was heard by the court, and she had voluntarily started to take lithium following her discharge.

Perhaps, the most troubling case is that of Paul Conway, who has avoided regular treatment with antipsychotic medication for over 25 years by initiating multiple, protracted and tenuous legal challenges. During this period, Mr. Conway has been detained in various psychiatric facilities and has been forcibly restrained on numerous occasions. Criminal Review Board records indicate that he responded well to the very limited medications that he had received³⁵. Apart from these brief periods, Conway's condition has not improved. Without treatment with the proposed medications, there appears little prospect of him regaining his freedom.

Discussion

The clinical information regarding these cases illustrate that antipsychotic medication is fundamental in the treatment of patients with severe and persistent mental illness. As predicted by their psychiatrists, 4 patients markedly deteriorated without antipsychotic treatment. Indeed, Starson almost died because of a delusional driven refusal to eat. Only Neto was discharged without treatment – possibly because she suffered from a bipolar disorder in which symptoms are usually cyclical and therefore more likely to remit spontaneously.

A number of these cases are regularly cited in legal decisions. For example, the SCC's decision in *Starson* is frequently cited by Ontario review boards and courts in reference to the elements of the capacity test and a capable patient's right to refuse treatment regardless of its impact on his or her health, safety or wellbeing. Moreover, as noted in the introduction, some authors infer from *Starson* that any provincial or territorial legislation, which does not give absolute priority to the advance directive of a currently incapable involuntary psychiatric patient would be vulnerable to a challenge under section 7 of the Canadian Charter of Rights and Freedoms³⁶.

The Supreme Court's comments in *Starson* about psychiatric drugs may have reinforced a negative view of these medications. The Court quoted, with approval, the Ontario Court of Appeal in *Reid* "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."³⁷ Neither the Supreme Court nor the Court of Appeal mentioned the scientifically proven positive effects of these drugs, which governments across the world have licensed as effective and safe.

It is ironic that *Starson*, *Reid* and *Gallagher* continue to be cited in support of a libertarian right to refuse psychotropic medication given that all 3 had to be detained for years in maximum security psychiatric facilities against their will, and that Starson almost died because of the lack of treatment, while Reid and Gallagher had to be forcibly restrained and repeatedly held in seclusion. Their clinical histories demonstrate that it was only the eventual administration of psychotropic medications that made it possible for each of these men to regain his freedom.

As noted in the introduction, research has already documented the many adverse clinical effects of withholding treatment from involuntary hospitalized patients^{16, 17, 18, 19, 20, 21, 22, 23, 26, 27}. The findings of the current study and of our earlier article¹⁵ show that failure to treat an involuntarily hospitalized patient also frequently leads to a serious infringement of that patient's right to liberty.

These outcomes demonstrate that withholding standard psychiatric treatment from a person who is involuntarily hospitalized is not in that person's best interests. The best interests of involuntary patients include not only the person's physical and mental wellbeing, but also their liberty. We accept the Supreme Court's interpretation of Ontario's current statutory test of capacity, namely that a person's best interests are irrelevant to this determination³⁸. However, clinical and legal outcomes - such as whether a statute subjects involuntarily detained patients to indeterminate detention - should not simply be ignored.

For example, legislation should not result in unnecessary incarceration due to prolonged delays in providing treatment for involuntarily hospitalized patients. In our first study, we noted an average delay of 253 days before treatment was started in cases where a review board's confirmation of treatment incapacity was appealed to the Ontario courts¹⁵. We also noted that in no case did a court overturn the CCB finding. Based on these findings, we recommended that treatment should begin once the CCB confirmed a physician's finding of treatment incapacity. This is the approach taken in Nova Scotia³⁹. We believe that this approach strikes an appropriate balance between rights to autonomy and health, while protecting a person's right not to be unnecessarily deprived of their liberty. The current study demonstrates that little, if any, harm would result from this approach. Very few involuntarily detained patients are found, on appeal to the courts, to have been capable or to have an applicable advance directive to forgo psychotropic medication. Even when the courts upheld a detained patient's right to refuse treatment, we have shown that most eventually receive treatment - though only after further prolonged periods of involuntary hospitalization.

Our findings also highlight the dangers of Ontario legislation governing advance directives. The issue of advance directives for involuntary patients is complex. Even the simpler issue of whether an involuntarily detained patient's competent refusal of treatment should prevail is controversial. Some argue that when the state deprives a person of his or her liberty because of the effects of a mental illness, the state has a duty to provide treatment for that illness so that the person can regain liberty⁴⁰. Other scholars⁴¹ and some courts⁴², view autonomy as a preeminent social value

that necessitates respecting a capable patient's right to refuse treatment in all situations. A full analysis of these differing perspectives is beyond the scope of this article and can be found elsewhere^{43, 44}.

The question of whether to accept an involuntarily detained and currently incompetent patient's advance directive to refuse treatment raises this debate to another level. An advance directive requires a person to make a treatment decision without knowledge of all pertinent future circumstances. A person may believe that he or she would prefer to be hospitalized forever rather than take antipsychotic medication. However, once the directive is made, if the person subsequently becomes incapable he or she cannot change that decision and, if involuntarily hospitalized, may face lifelong detention⁴⁵.

Moreover, Ontario law does not require that an advance directive be documented in any way – oral and written directives are equally binding⁴⁶. Nor is there a need for any evidence that the person was capable when the advance directive was made. Indeed, Ontario law presumes capacity unless there is clear evidence to the contrary⁴⁷.

Canadian jurisdictions have adopted different approaches to limit the harm to, or by, an involuntarily detained patient who has expressed a prior wish or executed an advance directive regarding psychiatric treatment. British Columbia⁴⁸ and Newfoundland and Labrador⁴⁹ do not recognize an involuntarily detained patient's advance directive regarding psychiatric treatment. In Saskatchewan, an advance directive is not binding, rather is used for guidance⁵⁰. Alberta⁵¹ and New Brunswick⁵² permit a review board to overrule a prior expressed refusal or advance directive if it is not in the patient's best interest. We would presume that prolonged and unnecessary deprivation of a patient's liberty would be viewed as not in the patient's best interest. The approach used in Manitoba⁵³ and Nova Scotia⁵⁴ views an expressed wish as nonbinding if it endangers the health or safety of the patient or others. This presumably could be used to ensure that a committed patient, who is at significant risk, receives treatment that may lead to the patient's release.

Each of these approaches would have avoided the severe problems encountered by Starson, Reid, Gallagher, Sevels and Conway. In our view, all are preferable to the Ontario legislation. At a minimum, to be binding, an advance directive should be made in writing, signed and be witnessed by a health care professional or lawyer who can attest to the person's capacity at the time of executing the directive. This is the model recently adopted by Scotland⁵⁵. It is also worth noting that under this Act the review board can still overrule a valid advance directive⁵⁶.

Summary

The Courts in Ontario seldom overturn decisions by the CCB pertaining to treatment refusal. Although the numbers are small, most of these patients do not regain their liberty without treatment. In attempting to protect autonomy, the Ontario law has exposed those it seeks to protect to indeterminate detention. Mental health legislation must balance the competing interests

of patients and other Canadian jurisdictions have adopted different legislative models to avoid the problem of inappropriate detention without treatment.

Funding and Support

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Capacity, Rights and Interests



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Abstract

This comment examines a recent study of cases in Ontario, Canada where the courts support the right of refusal of detained persons with mental illness to accept the specific modality of care requested by their treating psychiatrist. The comment i) discusses some conceptual issues underlying our understanding of freedom embedded in the right to refuse treatment by persons with mental illness; ii) notes and questions the exaggerated distaste for paternalism within the liberal jurisprudence expressed in this case; and iii) notwithstanding support for judiciously targeted concern for the interests over the choices of persons with mental illness in the courts, rejects any general shift to a policy of involuntary mental health interventions based upon a dramatic case study.

In 2003¹ the Supreme Court of Canada ruled that a judicial appeal process could overturn the professional judgment of treating psychiatrists and the ruling of an Ontario Consent and Capacity Board (OCCB) on a question of capacity. The person in question – we will call him “X” – had been justifiably² detained for a pattern of ostensible criminal conduct as a result of a mental disorder.³ At trial, X failed to meet even the very low threshold⁴ for fitness to stand trial until anti-psychotics were involuntarily administered. X was then found Not Criminally Responsible by virtue of Mental Disorder (NCR-MD). For over 5 years of detention, X was deemed simultaneously *capable* and [criminally] *non-responsible*, holding the right to refuse the treatment that might correct the mental disorder giving rise to the detention. X could be involuntarily detained but not treated.

Admittedly, this is not a purely logical contradiction. Trials concern events in time; mental status may change over time. Continued detention is grounded in the forward looking concern for ‘significant threat[s] to the safety of the public’⁵; not the administration of punishment for a past

¹ *Starson v. Swayze* 2003 SCC 32.

² Since there was a pattern of ostensible criminal conduct, the detention would satisfy the Winko criteria of addressing public safety from risk of criminal conduct: *Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] 2 S.C.R. 625. I say *ostensible* criminal conduct since the conduct would need to be accompanied by *mens rea*, absent which, it could arguably be deemed not to be criminal conduct.

³ Not Criminally Responsible as a result of a mental disorder (NCR-MD)

⁴ Bloom, H., “Psychiatric Issues in the Criminal Process”, in Hy Bloom and Michael Bay, *A Practical Guide to Mental Health, Capacity, and Consent Law of Ontario*, Carswell, 1996, p.266.

⁵ The language of the Supreme Court of Canada in *Winko*, discussed in Desmarais, S., Hucker S et al, “A Canadian Example of Insanity Defence Reform: Accused found not criminally responsible before and after the *Winko* decision”, *International Journal of Forensic Mental Health*, 2008, Vol. 7, No. 1, pp 1-14.

action. Once detained NCR-MD, X refused those medications earlier shown necessary to achieve fitness⁶ a refusal now deemed to have been made by a capable person.

The 2003 decision was widely applauded as a victory of freedom over paternalism. However, as these researchers tracked the case through the public record, they found that the victory was both pyrrhic and paradoxical: X was continuously detained with additional restraints and seclusions for the safety and needs of self and others. This victory for rights compromised freedom. In 2005, another OCCB⁷ ruling did find absence of capacity and, without a further appeal, X was treated involuntarily, improved dramatically and was released from hospital for the first time in almost seven years.

The researchers recommend that the contested treatment - in these precisely limited situations of legal appeal for NCR-MD detainees - proceeds while the lengthy court process unfolds. In that way, persons retain the right to challenge a treatment decision without undermining their interests or their freedom – or imposing other costs on the system. Nevertheless, there are some more general issues here.

1. Is the law consistent in its treatment of capacity and criminal responsibility?

For uttering death threats in the context of what a court took to be disordered, psychotic thinking, X was deemed to lack the constituents of rational, moral agency needed to establish criminal responsibility: it was the disease talking, not X. We might even say the criminal act for which X was tried, was not even committed by X; it was committed by a diseased, rogue self which had usurped X's higher, rational and moral self. A bit like Plato's tyrant⁸ and lacking what Isaiah Berlin might call positive freedom⁹, X's apparent freedom in choosing to utter death threats was, properly understood, a slavish manipulation by forces which should not have been in control. Untreated, X had no authentic self; there was no genuine freedom to protect.

Yet, detained in a secure hospital, X was presumed to possess sufficient capacity for rational agency (understanding relevant information, appreciating reasonably foreseeable consequences) to overrule recommended psychiatric care. Do we assume that X was a capable agent with regard to health care decisions but incapable with regard to criminal behaviour? What was it about X's delusional thinking that warranted the courts to entrust the choice of health care to personal discretion but reinforce detention to secure the safety of others? It is hard to articulate a construction of the *self* which can bear the weight of this fearful asymmetry.

⁶ Gray, JE and O'Reilly RL, *Supreme Court of Canada's "Beautiful Mind" case*, International Journal of Law and Psychiatry, forthcoming.

⁷ (Re) Professor S., [2005] O.C.C.B. No. 49

⁸ Plato, *The Republic*, Indianapolis, Hackett, 1974.

⁹ Berlin, I, (1958) "Two Concepts of Liberty", in Isaiah Berlin, *Four Essays on Liberty*. Oxford OUP, 1969. Berlin, of course, warns of the danger to negative freedom when we impose some version of the "real" self over the 'empirical' self in the name of 'higher' freedom.. However, he adds, "that I may be coerced for my own good, which I am too blind to see ... may, on occasion, be for my benefit; indeed it may enlarge the scope of my liberty."

The authors' contention is that X's freedom – the negative freedom of non-interference – is advanced by the paternalism of involuntary treatment. Through it, X becomes well enough to leave the forensic hospital. But in another sense X's positive freedom is also advanced. The rogue self is silenced and X reverts to or acquires a more authentic version of agency. Hence the intertwined paradox: if we respect X's negative freedom to choose not to be treated, X suffers more restraint and undermines the prospects for moral agency. Whereas, if X is involuntarily treated, restraints are lessened and the conditions of a more authentic and "normal" autonomy are restored, but against X's prior stated wishes.

This begs a further line of questions, for which I have no satisfying answers. What is an authentic version of agency and how much bio-medical 'Clockwork Orange' tinkering do we want to entertain in the interests of freedom? Or, indeed, following BF Skinner¹⁰ but armed now with measures of dopamine and serotonin regulation¹¹ in addition to operant conditioning, is freedom as important as we think in cases where its judicial defense is so obviously self-defeating?

2. What of X's interests?

When the right of treatment refusal was eventually overruled years later, the decision was said to turn upon capacity. On the face of it this was certainly the case. The SCC 2003 ruling displayed an almost principled disregard for any question of welfare or best interests. As long as X could "understand the information ... relevant to making a decision about the treatment . . . and . . . appreciate the reasonably foreseeable consequences of a decision or lack of decision"¹² X would be permitted to refuse treatment. Notice, though, the two concepts, *relevance* and *appreciation*, which are in play here.

In the second OCCB hearing which enforced neuroleptic treatment, the evidence put forward was such as to suggest that X would likely die if he did not receive this anti-psychotic medication. Yet, X was already on record saying that such medication would be, for him, "worse than death"¹³. In other words, he could *appreciate* the consequences of taking or not taking medication but his version of what was *relevant* to that decision was not what the court took to be relevant. X preferred the self-understanding of galactic agent to the mediocre role of a psychiatric patient; X preferred to die rather than become normal¹⁴.

By the time of the 2005 hearing X was too weak to think. If X's prior known wishes, however, were respected or if X had issued an advance directive, a Board that truly honoured the capacity of choosing over the quality of the choice might have allowed him to die. It is good that it did not. But in ruling as it did, it has surely brought into play elements of some objectively conceived

¹⁰ Skinner BF, *Beyond Freedom and Dignity*, New York, Knopf, 1971

¹¹ See for example, Glannon, W., *Bioethics and the Brain*, p.101

¹² 2003 SCC 32, Quoting here the text of the Ontario Health Care Consent Act 1996

¹³ 2003 SCC 32 par. 102

¹⁴ "a term so boring it would be like death" *ibid* par. 102

notion of *best interest*: life is better than death. Paranoia with regard to paternalism required that X's best interests could only be introduced in the guise of lost capacity.

Societies which value individual liberty may still endorse appropriate expressions of paternalism. J S Mill, in *On Liberty*, for example proscribed contracts of voluntary slavery¹⁵. He argued that the freedom to enter such contracts defeated the purpose of liberty's defense. A similar argument is available, I would suggest, in cases of persons detained NCR-MD: with no advantage to freedom, negatively or positively conceived, whose interest and what freedoms are served here?

3. This powerful case is apt to become iconic. But, it is one case.

In 15 years of investigation, the authors found only six cases in Ontario of judicial support for treatment refusal by persons detained NCR-MD. It does seem from their evidence that these persons might have been better off with imposed treatment. However, these cases need to be placed in the context of all clients treated involuntarily and voluntarily with similar clinical profiles. Persons with mental illness are routinely treated voluntarily and successfully.

Engaging with providers to balance the risks and benefits of individual treatment regimens is, arguably, an important condition of empowerment, dignity and recovery. To infer from the particular details of a dramatic case study, the need for a *general* shift in the direction of paternalistic treatment would be methodologically unsound and unwise.

¹⁵ Mill, JS, *On Liberty*, Penguin, Harmondsworth, 1984, p.173: "The principle of freedom cannot require that he should be free not to be free. It is not freedom to be allowed to alienate his freedom." Elsewhere, Mill strongly implies that the exercise of freedom ought to be restricted to those with "the full use of the reflecting faculty". (p.165)

Response to “Capacity, Rights and Interests”

Richard O’Reilly, M.B, F.R.C.P.C, Robert Solomon, LL.B., LL.M., John Gray, Ph.D.

Dr. State has written an erudite account on the definitions and meaning of liberty for individuals who suffer from serious mental illness. Not surprisingly, he has struggled with the ironic deprivation of liberty caused by the judicial appeal process of the current law in Ontario. Alas, we cannot agree with his conclusion wherein he “...rejects any general shift to a policy of involuntary mental health intervention based upon a dramatic case study.”

First, we do not recommend a general shift of policy. Rather we recommend a simple change in the legal procedure whereby treatment would start after the first level of legal review by the Consent and Capacity Board. The patient could continue to appeal to the courts but would be treated in the interim. We also recommend that Ontario’s binding advance directives, which may condemn a patient to life-long detention or death, should be written, signed and witnessed. Hardly general policy shifts.

Second, we do not base our recommendations on a single case – quite the opposite. The law needs to change not *despite* but *because* there are so few cases where the courts overruled the CCB. We found that in 20 years the courts overturned the CCB findings in only 6 cases. Moreover, we found that 4 of these individuals were eventually treated after years of detention. One individual remains detained and untreated for 25. Therefore only one individual, Ms N., who was found incapable by the CCB but capable by a court, avoided the medication she initially refused. Interestingly, even she had voluntarily taken one of the medications, lithium, by the time of the court ruling.

The real question is: should the single case of Ms. N. prevent the law from changing to prevent hundreds of patients being detained for months or years without treatment. In our previous work we showed that in two hospitals in the 1990s almost one patient per year appealed a CCB confirmation of their capacity to the courts. The courts upheld all cases they heard but the average delay initiating treatment was 253 days. What we propose is practical, makes good sense, promotes liberty and is already in place in other Canadian provinces.