The Right to Refuse Treatment: Recent Canadian Developments

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In this article, we examine one of the most contentious and divisive issues in mental health law: the right of the involuntary patient to refuse treatment. The recognition of this right can be traced to American case law starting in mid-1970s. The passing of the Canadian Charter of Rights and Freedoms in 1982 precipitated somewhat similar developments in Canada. Many provincial Mental Health Acts have been changed to reflect this newly acknowledged right. In addition, there have been two recent court decisions in Canada, *Thwaites v. Health Sciences Center* and *Fleming v. Reid*, which reflect the impact of the Canadian Charter on this issue. The right to refuse treatment has implications for the field of psychiatry.

The right to refuse treatment has become increasingly important in Canadian mental health law. Rights of Canadian psychiatric patients are delineated in provincial Mental Health Acts; each province has a different Mental Health Act. In the last decade, the majority of provinces are amending their Mental Health Acts to allow for a greater recognition of the right of the involuntary patient to refuse treatment.[1]

Historically, involuntary commitment in Canada arose from the *parens patriae* rationale of the need for treatment. One of the central aims of involuntary hospitalization was to provide treatment for the mentally disordered. Civil commitment, therefore, implied involuntary treatment. The idea that involuntary patients would have the right to refuse treatment was not even considered.[2]

In the mid-1970s, U.S. civil rights advocates, after successfully arguing for the rights of minorities, turned their attention to psychiatric patients. They argued for a greater recognition of the general rights of involuntary patients and for the specific right of these patients to refuse treatment. Since a voluntary patient cannot be treated against his or her will unless found incompetent to make treatment decisions, they reasoned that an involuntary patient should have a similar right.[3]

Since the late 1970s, an increasing number of American state courts have recognized this common-law principle of informed consent. The state courts have been less responsive to countering arguments, namely, economic consid-

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erations about minimizing treatment cost and the need of mentally ill patients to be treated. These state courts are adopting models which allow involuntary competent patients the right to refuse treatment[3–5] and provide for a mechanism whereby a review board or court makes treatment decisions for involuntary incompetent patients based either on their "best interest" or on the wishes of a substitute, called "substitute decision-making."[6, 7]

The passing of the Canadian Charter of Rights and Freedoms in 1982[8] provided the legal impetus for similar changes in Canada. "Patient rights" advocates have argued that it was not only unethical to force treatment on competent patients involuntarily hospitalized,[9] but it is contrary to the Charter.[10, 11] The following sections of the Charter are relevant to provincial Mental Health Acts:

> Section 7, 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; Section 9, the right not to be arbitrarily detained; Section 12, the right not to be subjected to any cruel and unusual treatment or punishment; and Section 15, every individual is equal before the law and has the right to equal protection and benefit of the law without discrimination.[8]

A number of provinces have responded by amending their provincial Mental Health Acts so as to make them more consistent with the Charter.

Recent Canadian Jurisprudence

Some provinces have recognized the right of an involuntary patient to refuse treatment. Nova Scotia was the first province to do so, even before the passing of the Charter. Under amendments to its Mental Health Act passed in 1977, a competent patient who has been involuntarily committed to hospital may refuse treatment. The issues involved in determining competency to make treatment decisions are the ability of the patient to understand his or her illness, the nature of the treatment proposed, and the risks and benefits of accepting or rejecting that treatment.[12–14]

After the passing of the Charter, a number of other provinces passed similar legislation. In 1986, the Manitoba Legislature significantly amended its Mental Health Act. According to the amendments, an involuntary patient may refuse treatment if he or she is competent to make treatment decisions. Similarly, the Ontario Mental Health Act of 1987 recognizes absolutely the right of a competent patient to refuse treatment even if involuntarily hospitalized. A refusal of treatment by a competent patient cannot be overridden by a review board in Nova Scotia, Ontario, or Manitoba.

Other provinces have not gone as far in recognizing the right of involuntary patients to refuse treatment. While the Alberta Mental Health Act has allowed for an involuntary competent patient to refuse treatment, it has provided for a review board which may override this decision. Similarly, in New Brunswick, the Mental Health Act allows for a tribunal to override the competent wishes of an involuntary patient.

These provinces have also provided for a process of dealing with involuntary patients who are found incompetent to make treatment decisions. In these

models, the "best interest" of the patient is paramount, over and above the wishes of the substitute. The Ontario Mental Health Act of 1987 is illustrative of this. If an involuntary patient is not competent to make treatment decisions, a "substitute" may make treatment decisions on behalf of the patient. The substitute is the closest relative as defined by provincial legislation or, in the absence of a close relative, the official guardian. The substitute makes the treatment decision based on what the patient, when competent, has desired. However, the review board can override the decision of the substitute and authorize the treatment it considers to be in the "best interest" of the patient.

The Saskatchewan Legislature has adopted a different approach. According to amendments to the Saskatchewan Mental Health Act passed in 1985, civil commitment and competency to make treatment decisions are addressed simultaneously. Incompetency to make treatment decisions is a necessary condition for involuntary hospitalization. As a result, only incompetent patients may be involuntarily admitted.

Some provinces have not recognized the right of involuntary patients to refuse treatment. In British Columbia, the Mental Health Act of 1990 allows for a medical director to make treatment decisions on behalf of involuntary patients. Similarly, in Newfoundland, treatment may be given to involuntary patients without their consent. The Mental Health Acts of Prince Edward Island and Quebec do not deal with this issue directly.[1,2]

The Right to Refuse Treatment and the Canadian Charter

Several provincial Mental Health Acts have been amended to provide for a greater recognition of the right of involuntary patients to refuse treatment. These changes have been prompted at least in part by a concern that earlier provisions in the provincial Mental Health Acts were inconsistent with the Charter. Two recent cases, *Thwaites v. Health Sciences Center*[15] and *Fleming v. Reid*[16] provide some insight into how courts interpret the Charter in the context of mental health legislation.

A decision of the Manitoba Court of Appeal in October 1988 resulted in changes to portions of the Manitoba Mental Health Act dealing with the right of involuntary patients to refuse treatment. On May 29, 1986, Thwaites was involuntarily committed to the Health Sciences Centre in Winnipeg. Her lawyer immediately initiated legal proceedings, claiming that the compulsory admission provisions of the Provincial Mental Health Act offended the Charter. Although the case was dismissed by the Court of Queen's Bench, the Manitoba Court of Appeal concluded that the involuntary commitment provision did violate Section 9 of the Charter. Those sections of the Manitoba Mental Health Act were declared unconstitutional on February 29, 1988.

Bill 59 was proclaimed by the legislators the following day. This bill is a significant series of amendments designed to make the Manitoba Mental Health Act more consistent with the Charter. Among other things, the Act

states that involuntary patients who are competent to make treatment decisions may refuse treatment.

The amendments to the provincial Mental Health Act had been passed by the Manitoba Legislature several months earlier. However, because of strong objections from the psychiatric community, the bill had not been proclaimed. Psychiatrists were dissatisfied with the amendments for a number of reasons, including concerns about the provision which enabled involuntary competent patients to refuse treatment. The decision by the Manitoba Court of Appeal to strike down provisions of the Mental Health Act forced the government to proclaim Bill 59.[17]

The decision of the Ontario Court of Appeal in Fleming v. Reid deals more directly with the implications of the Charter on the right to refuse treatment. The Fleming case involved two schizophrenic patients at a psychiatric facility in Ontario who were involuntarily hospitalized and incompetent to make treatment decisions. Both patients when mentally competent had indicated they would not want treatment. Accordingly, the official guardian, as substitute decision-maker, refused treatment. The attending psychiatrist wanted to institute treatment with neuroleptics and applied to the review board for authorization. The review board ordered the proposed treatment. The patients' lawyer commenced legal proceedings which led the Ontario Court of Appeal to set aside the order, deciding that pertinent provisions of the Mental Health Act violated the Charter.

The decision of the Ontario Court of Appeal was based on the right of the mentally competent patient to refuse treatment. The Court examined the provisions of the Ontario Legislature that allow a review board to disregard the wishes of a competent patient and mandate treatment based on the patient's "best interest." It decided that this provision was inconsistent with the "right to life, liberty, and the security of person" and contravened "the principles of fundamental justice." It declared relevant provisions of the Ontario Mental Health Act unconstitutional and in violation of Section 7 of the Charter, "the right to life, liberty, and the security of the person." The Court could not justify the infringement as "a reasonable and minimal violation." The Court could not find a compelling reason for eliminating the right of a competent person to refuse psychiatric treatment.[18, 19]

This decision may serve as a precedent and provide an impetus for litigation in other provinces. In addition, it may prompt other provinces to amend their Mental Health Acts along similar lines.

These cases are particularly significant when viewed in conjunction with developments on the federal level. In *R. v. Swain*, the Supreme Court of Canada decided that key sections of the Criminal Code dealing with the mentally disordered violated the Charter. The federal government, in response to this decision, revised pertinent sections of the Criminal Code in order to be more consistent with the Charter.[20] There is an expectation by the government that provinces

will also reexamine the Mental Health Acts in terms of the Charter.[21]

Implications for Treatment

The two recent Charter decisions have implications for the practice of psychiatry in Ontario and Manitoba. The effect of these decisions on two forensic units, a 14-bed unit in Winnipeg, Manitoba in central Canada, and a 16-bed unit in Ottawa, located in Southeastern Ontario, were examined. Both forensic units were minimum security and primarily received referrals from the Courts. There has been no apparent change in the referral source or in the kind of patients referred to these units over the past few years. In general, the typical referral issue on either unit was assessment and, in some cases, treatment, of a mentally ill patient presently before the Criminal Courts. Forensic units as opposed to general units were studied because of the higher incidence of treatment refusal on those units.

In Ontario, as a result of *Fleming v. Reid*, the review board cannot override the decision of the substitute decision-maker. There are also a number of other more subtle changes to the practice of the review board that can be related, at least in part, to this decision. The review board proceedings, in general, have become much more adversarial and legalistic. The board is very reluctant to authorize treatment unless the appropriate substitute decision-maker is found. Finally, patients are notified upon being admitted to a hospital of their right to appoint a substitute in the event of becoming incompetent.

In looking at the 16-bed minimum security forensic unit in Ottawa, we can see difficulties created by these changes. The more adversarial and legalistic nature of review board hearings increases the amount of clinical time expended on a case as well as the length of delays resulting from these hearings, with some cases requiring more than one hearing. The fact that review boards are reluctant to authorize treatment unless the appropriate relative by law acts as the substitute can mean more delays in treatment. Finally, the requirement that patients be given a notice informing them of the right to appoint a substitute has resulted in cases where the patient chose an individual to deliberately obstruct the treatment process. In one case, the patient chose the head of the Church of Scientology as the substitute decision-maker. While the appointment was eventually overturned, it required two review board hearings and a 30-day delay. During these delays, i.e., the period between when the patient appeals his or her status and the review board renders a decision, treatment cannot be instituted.

From April 1988 to March 1989, the average length of stay was 37.4 days. From April 1992 to March 1993, the average length of stay on the forensic unit was 56.7 days, a 54% increase. This supports the clinical observation that recent changes in review board procedures delay treatment and prolong hospitalization in a forensic unit. It is important to note that these problems may not be as apparent on a general unit where treatment refusal is less common.

By contrast, the experience in Manitoba has been more benign. The *Thwaites v. Health Sciences Centre* decision brought about a series of amendments to the Manitoba Mental Health Act including the right of involuntary competent patients to refuse treatment. However, the implementation of these changes has been less problematic than in Ontario. The review boards are less adversarial and more focused on the best interest and well-being of the patient than on legalistic concerns. It is easier to obtain treatment authorization from the Public Trustee in the event that an appropriate substitute cannot be found. The review board can override the treatment decision of a substitute if it deems it to be in the best interest of the patient. Finally, treatment can be instituted even during the period when the patient is appealing his or her status and the review board has not authorized treatment. As a result, review board hearings do not necessarily delay treatment. Furthermore, on commencement of treatment, many patients cancel their review board applications.

In looking at the minimum security forensic unit in Winnipeg, there was no increase in length of stay or delays in treatment in the hospital due to review board hearings. The one case of a patient appealing a judgment of incompetency to make treatment decisions was decided in favor of the physician. Moreover, the less adversarial nature of these review board hearings meant that it did not require a large amount of clinical time. There were eight other review board applications (two applications involving involuntary status, three applications involving competency to make treatment decisions, and three applications involving both). These applications were withdrawn before being heard by a review board.

Discussion

Developments on both the provincial and the federal levels suggest a continuation of the trend toward allowing competent involuntary patients the right to refuse treatment. In addition, we may see greater use of the substitute decision-maker model for involuntary incompetent patients.

These changes can be seen as necessary safeguards. Allowing a single clinician complete discretion in choosing medications carries with it the potential for misuse. By making a review board oversee the process, the treatment decision arrived at is often a consensus among several clinicians. However, these protections are in some ways redundant, as there are already hospital committees ensuring quality management and fairly stringent criteria for specialty training in psychiatry.

Certainly the effects of the right to refuse treatment have been less dire than some psychiatrists initially feared. Psychiatric hospitals have not become detention centers for patients refusing treatment. The overwhelming majority of patients do receive the necessary treatment. Most involuntary patients accept treatment, although some will initially refuse. The small percentage of patients, less than 10%, who persist in refusing treatment are often incompetent and

have treatment decisions made on their behalf.[22]

However, the recognition of the right of involuntary patients to refuse treatment has not been without cost. There are an increasing number of procedural hearings related to psychiatric patients appealing their legal status. For example, in 1989, 10% of involuntary patients in Ontario appealed their incompetency status to the Review Board. Although the mechanism for dealing with these appeals varies from province to province as can be seen by the comparison of a forensic unit in Ottawa with one in Winnipeg, in general these procedures are cumbersome and time consuming. At a time when there are already fairly significant cutbacks in resources for the mentally ill, additional expenditures of resources and clinical time are costly.[23]

The situation in the U.S. has been even more fraught with difficulties. Many states, in recognizing the right of involuntary patients to refuse treatment, have created a much more complicated and tedious review of the process. These procedures have resulted in lengthy delays in treatment and significant clinical time expended in the review process.[24–28] If the rights of involuntary patients continue to be enhanced, we may develop similar difficulties in Canada.

In summary, we are seeing increasing legislative and judicial support for the right to refuse treatment in Canada. The Canadian Charter of Rights and Freedoms is being used as a vehicle to expand that right.

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