Justifying Involuntary Psychiatric Treatment in Canadian Law: Competence, Autonomy, and the Narrative Analysis

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Abstract

Respect for individual autonomy is a foundational value which informs the legal and ethical considerations and requirements involved in medical decision-making. In Canadian law, respect for autonomy is instantiated by the requirement for obtaining informed consent from a person before providing them with medical treatment. Absent such consent, unwanted treatment may be considered medical battery and contrary to medical ethics.

The presence and impact of mental illness can complicate the process of obtaining informed consent as the illness may negate the person's capacity to make decisions or communicate them. In cases where a patient can be psychiatrically assessed as mentally incompetent to provide consent, law and ethical policy permit a degree of medical paternalism to provide for acting in the medical best interests of the patient, notwithstanding a lack or even refusal of consent on the part of an incompetent patient.

A more ethically and legally challenging case arise in those cases where the presence of a mental illness has impaired or substantially impacted a person's preferences and reasoning, however not to the extent that they would be assessed mentally incompetent. In these cases, the person may be at significant risk of self-harm and may deteriorate without treatment, yet sufficiently competent to refuse treatment.

This thesis engages in an analysis of different legal and ethical approaches to involuntary psychiatric treatment within the Canadian legal context and the western medical ethics tradition. Each Canadian jurisdictions is governed by its own mental health legislation, yet despite the different approaches, all must comport with the Canadian Charter of Rights and Freedoms.

After analyzing the different legal approaches to involuntary psychiatric treatment in Canadian statute and common law, it is argued that, while each approach has benefits and drawbacks, the frequent emphasis on mental competence as the deciding factor in whether and how involuntary treatment can occur facilitates the potential for one of two unsatisfactory circumstances: first, individuals may be "warehoused" in institutions because they are dangerous to themselves or others, yet shall remain untreated because they are competent to refuse treatment and many do so; second, individuals who are competent but at a substantial risk of self-harm or deterioration *may be left to their own devices, neither admitted nor treated, on the basis of a competent refusal of treatment.*

Reliance on mental competence as being the determining factor in implementing involuntary psychiatric treatment is intuitive liberal, however this thesis proceeds to analyze the legal and ethical understandings of personal autonomy, such as it relates to informed consent and involuntary psychiatric treatment. A more robust understanding of autonomy, particularly informed by modern bioethical and feminist critiques, suggests that deference to refusals of psychiatric treatment may result in an overall loss of autonomy, rather than the protection of it, which was a principal goal of the liberalization of mental health law and policy.

In order to address the concern of (competent) psychiatric patients refusing treatment to their detriment when their refusal may be substantially motivated or impacted by the symptoms of their illness, I propose that a narrative accounting of the patient's own treatment history, preferences, and values, over time, should be considered in deciding whether or not they can be treated against their will. This approach preserves the liberalism of respecting their own choices, but provides for a non-arbitrary measure of whether or not their present refusal of treatment is authentic, and therefore a meaningful exercise of their autonomy, or the result of a drastic or sudden change in their judgment precipitated by their illness, which I argue ought not be considered an act of autonomy.

Résumé

Le respect de l'autonomie individuelle est une valeur fondamentale qui informe les considérations et des exigences impliquées dans la prise de décision médicale juridiques et éthiques. En droit canadien, le respect de l'autonomie est instancié par l'exigence d'obtenir le consentement éclairé d'une personne avant de leur fournir un traitement médical. Tels l'absence de consentement, le traitement peut être considéré comme indésirable batterie médicale et contraire à l'éthique médicale.

La présence et l'impact de la maladie mentale peuvent compliquer le processus d'obtention du consentement éclairé que la maladie peut annuler la capacité de la personne à prendre des décisions ou de communiquer entre eux. Dans les cas où un patient peut être psychiatrique évaluée comme mentalement incapable de donner son consentement, le droit et la politique d'éthique de permettre un degré de paternalisme médical à fournir pour agir dans le meilleur intérêt médical du patient, malgré un manque, voire le refus de consentement de la part d'un patient incompétent.

Un cas plus éthiquement et juridiquement difficile se pose dans les cas où la présence d'une maladie mentale a une déficience ou sensiblement impactés les préférences et le raisonnement d'une personne, mais pas dans la mesure où ils seraient évalués mentalement incapable. Dans ces cas, la personne peut être à risque important d'automutilation et peut se détériorer sans traitement, encore suffisamment compétente de refuser un traitement.

Cette thèse se livre à une analyse des différentes approches juridiques et éthiques à un traitement psychiatrique involontaire dans le contexte juridique canadien et la tradition de l'éthique médicale occidentale. Chaque juridictions canadiennes est régi par sa propre législation sur la santé mentale, mais, malgré les différentes approches, tous doivent comporter à la Charte canadienne des droits et libertés.

Après avoir analysé les différentes approches juridiques à un traitement psychiatrique obligatoire dans la loi canadienne et la common law, il est soutenu que, bien que chaque approche a ses avantages et inconvénients, l'accent sur la compétence mentale fréquents comme le facteur décisif de savoir si et comment le traitement involontaire peut se produire facilite la potentiel pour l'une des deux conditions peu satisfaisantes: d'abord, les individus peuvent être "entreposés" dans les établissements parce qu'ils sont dangereux pour eux-mêmes ou d'autres, encore sont pas traités

parce qu'ils sont compétents pour refuser un traitement et beaucoup le font; Deuxièmement, les individus qui sont compétents, mais à un risque important d'automutilation ou de détérioration peuvent être laissés à eux-mêmes, ni admis, ni traités, sur la base d'un refus compétente de traitement.

Reliance sur la compétence mentale comme étant le facteur déterminant dans la mise en œuvre un traitement psychiatrique involontaire est libérale intuitive, cependant cette thèse procède à analyser les interprétations juridiques et éthiques de l'autonomie personnelle, telle qu'elle se rapporte au consentement éclairé et le traitement psychiatrique obligatoire. Une compréhension plus robuste de l'autonomie, particulièrement informé par les critiques de bioéthique et féministes modernes, suggère que la déférence à un refus de traitement psychiatrique peut entraîner une perte globale de l'autonomie, plutôt que la protection de celui-ci, qui était un des objectifs principaux de la libéralisation de la santé mentale droit de la santé et de la politique.

Afin de répondre à la préoccupation des patients psychiatriques (compétentes) de refuser un traitement à leur détriment quand leur refus peut être sensiblement motivé ou influencé par les symptômes de leur maladie, je propose que la comptabilité de récit de sa propre histoire de traitement, les préférences et les valeurs du patient , au fil du temps, devraient être considérés dans décider si oui ou non ils peuvent être traités contre leur volonté. Cette approche préserve le libéralisme de respecter leurs propres choix, mais prévoit une mesure non arbitraire de si oui ou non leur refus actuel de traitement est authentique, et donc un exercice significatif de leur autonomie, ou le résultat d'un changement radical ou soudain dans leur jugement précipité par leur maladie, que je soutiens ne doit pas être considéré comme un acte d'autonomie.

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CHAPTER 1: Introduction

It is a fundamental tenet in both law and medical ethics that a person's autonomously made decisions concerning their own medical treatment should be respected. This respect is manifested in the ethical and legal obligations to obtain and abide by a person's consent or refusal of consent to medical procedures and treatments. Psychiatric paternalism, which may include attempting to persuade or compel patients with mental illness to undergo treatment, presents a challenge to the duty to respect personal autonomy, as the impact of mental illness may diminish the patient's competence to consent or may cause shifts in their values and preferences with respect to treatment. Respecting the patient's decision in these cases is more difficult given that honoring a refusal of psychiatric treatment may be likely to lead to a deterioration in the patient's health.

The purpose of this work is to examine Canadian mental health law as it pertains to the authorization of involuntary psychiatric treatment. Medical treatment in the general sense is predicated on informed consent, however, the legal regulation of involuntary psychiatric treatment makes an exception to this general rule and permits involuntary treatment in some cases. Such an exception should be grounded with legal, medical, and ethically sound reasoning. To that end, I employ an interdisciplinary approach to answer the overarching question: how should Canadian law be structured so as to facilitate ethically sound involuntary treatment of patients who are competent but suffering from a mental illness?

Each of the three disciplines considered grapple with this issue share a fundamental focus or concern around which this question is addressed, and that is: how to respect the individual's autonomy. In the legal sense, Canadian law has enshrined the concept of informed consent in the common law through the *Canadian Charter of Rights and Freedoms*.[1] In the sphere of medicine, there may be tension between respecting patient autonomy and acting paternalistically, in the patient's best medical interests, when the physician believes that treatment is warranted while the patient refuses. In terms of philosophy and the medical ethics discourse, the majority of the literature affirms personal autonomy as the pre-eminent value to consider, yet determining what exactly constitutes a patient's autonomy or a valid expression thereof becomes the subject of debate when mental illness is a factor. Interestingly, as Jose Miola points out, this in turn circles

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[1] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (UK), 1982 c 11.

back to the issue of law as "for as long as courts and ethics have existed, their interconnection has been nothing if not inevitable"[2] Indeed, the relationship between law and bioethics is both reciprocal and parallel.[3]

These myriad of legal and ethical issues pertaining to involuntary psychiatric treatment is somewhat simplified in the case of severe mental illness, where the symptoms of the illness function to distort a person's reasoning capacity or mental competence to the extent that they could be considered medically or legally incompetent. The more difficult ethical and legal question, and the one which I aim to address substantively in this work, is:

Under what circumstances can people who, though impacted by mental illness to some extent, ***remain competent*** *to consent or refuse consent to medical treatment, nonetheless receive psychiatric treatment without their consent.*

There is a pressing need to examine mental health legislation in light of the principle of autonomy, as some commentators have aptly pointed out that "mental health legislation may not fully reflect either coherent philosophical arguments or the various Conventions and Declarations [pertaining to patients' rights], since legislation is influenced by the specific historical, social, political, and cultural context in which it is enacted."[4] On the one hand, there may be an impetus not to treat psychiatric patients against their will because of the potentially damaging and stigmatizing effects of involuntary treatment. On the other hand, the rationale in favour of earlier compulsory treatment (during the early onset of an illness) is that earlier treatment correlates with a decrease in the rate and intensity of acute admissions to psychiatric hospitals and a decrease in the likelihood of violent

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[2] Jose Miola, "The Relationship Between Medical Law and Ethics" (2006) 1 Clinical Ethics 22.

[3] Daniel Sperling notes several reasons why the law's influence on bioethics is important. One reason is that they develop using similar methodologies. The common-law tradition resembles the principlism approach in ethics, which involves applying a series of moral principles to a situation in order to determine its outcome. The common-law approach in law is also reminiscent of the casuist approach in ethics, as both invoke concrete case-based reasoning, seeking to make the right decision in the first instance, and uphold that precedent in similar cases. Another related reason which Sperling gives for the importance of law's interaction with bioethics is that the authority-conferring power of law, which is both social and moral in nature, has the effect of increasing trust in the medical establishment. Sperling also points out that laws integration in the bioethical discourse is also predicated on the false assumption that the law reflects socially agreed upon ethical norms and values. See Daniel Sperling, "Law and Bioethics: A Rights-Based Relationship and Its Troubling Implications" in Michael Freeman, ed, *Law and Bioethics: Current Legal Issues 2008, Volume II* (Oxford, NY: Oxford University Press, 2008) 52 at 57-59.

[4] EC Fistein *et al,* "A Comparison of Mental Health Legislation from Diverse Commonwealth Jurisdictions" (2009) 32:3 International Journal of Law and Psychiatry 147 at 148.

events, as well as better clinical outcomes with early treatment, and reduced chance for intervening adverse events when treatment is delayed.[5]

I note that in this thesis I will not be discussing the important issues of patients' positive rights of access to adequate mental health care.[6] This discussion emanates from the civil rights discourse and concerns the obligations of a state to provide mental health care to those who need it, particularly for those who are unable to avail themselves of it due to their illness, social stigmatization, poor economic status, or other disadvantages.[7] These discussions and critiques are expansive in themselves and critical to the evolution of mental health law, however they generally concern the provision of care to patients who do not object to it. Given the focus of this work is on competent objecting patients I will only reference patients' rights to treatment insofar as they bear on the issue of providing mental health care to competent, objecting individuals.

A. Methodology and Outline

Any discussion of mental competence and the appropriate response to involuntary mental health treatment will necessarily be interdisciplinary as theory from philosophy, psychiatry, and law each converge upon it.[8] I will be discussing each of these disciplines in order to both frame and answer the question I have posed. The balance of this work is divided into the following sections:

1. Defining key concepts: schizophrenia and mental competence

I begin by providing background into the disease of schizophrenia, as well as the methodologies which mental health professionals use to assess competence to consent to treatment. The central focus of this thesis is then problematized in the case of involuntary psychiatric

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[5] Robert Hayes et al. "Evidence-based Mental Health Law: The Case for Legislative Change to Allow Earlier Intervention in Psychotic Illness" (2007) 14:1 Psychiatry, Psychology and Law 35 at 40. Notably this article pertained to risks of dangerousness and homicide due to mental illness, however the rationale therein for earlier treatment applies to any case where a deterioration in mental health is likely.

[6] Most judicial intervention concerning mental health legislation in Canada only concerns infringements of negative rights guaranteed by the *Charter* such as, for example, the rights to liberty and security of the person (section 7), which are potentially impugned by compulsory detainment and treatment. See Joaquin Zuckerberg, "Jurisdiction of Mental Health Tribunals to Provide Positive Remedies: Application, Challenges, and Prospects" (2012) 57 McGill L J 267 at 270, 281.

[7] Positive obligations on the part of the state as well as the need for a social and legal evolution in the provision of mental healthcare are a necessity. See H Archibald Kaiser, "Imagining An Equality Promoting Alternative to the Status Quo of Canadian Mental Health Law" (2003) Health L J 185; Beverley McLachlin, "Medicine and the Law: The Challenges of Mental Illness" (2010) 33 Dalhousie L J 15.

[8] For a detailed discussion on the history of all three disciplines relating to competence and mental health, see Gareth S Owen, Fabian Freyenhagen, Genevra Richardson, Matthew Hotopf, "Mental Capacity and Decisional Autonomy: An Interdisciplinary Challenge" (2009) 52:1 Inquiry 79.

treatment for schizophrenia in particular. It is necessary to narrow the scope of analysis to a specific set of facts which can be considered meaningfully within this work. Schizophrenia is utilized as an exemplar case because, as discussed in Chapter 2, its symptoms manifest on a spectrum in terms of type and severity, which in turn produces a range of impacts on perception and decision-making ability, without necessarily rendering the subject mentally incompetent to make medical decisions. This "gray area" exemplifies the tension at the center of this work, that being between respecting competent decisions of an individual versus treating them paternalistically. I note that many of the arguments discussed in this work could arguably be applied to a number of mental illnesses, particularly those which involve disturbances in thought but which tend to be of temporary or intermittent effects and which can be relatively well-managed with medication or other therapies, such as bi-polar disorder, anorexia nervosa, etc. It is for the purposes of simplicity and brevity, however, that I am limiting my discussion of the law and philosophy behind treatment refusal in mental illness to the specific context of schizophrenia.[9]

2. Canadian approaches to mental health law

I then discuss and contrast the approach taken to involuntary commitment and treatment across Canadian jurisdictions, as well as the relevant *Charter* jurisprudence which defines the legal and constitutional conception of personal autonomy. I discuss the exemplar case of *Starson v Swayze,* considered by the Supreme Court of Canada, for its excellent illustration of the competing legal and ethical issues at the heart of involuntary psychiatric treatment.[10] This lays the groundwork for assessing potential approaches for involuntary psychiatric treatment, as any such alternatives to the current regimes would still have to comport with the values enshrined within the *Charter*. This discussion includes consideration of legal commentary which bears on involuntary treatment in particular.

3. Bioethical concepts of autonomy

I discuss the philosophy behind autonomy in the medical context, contrasting the prolific mainstream individualistic conceptions of autonomy, and the mainstream bioethical theory of principlism, with the more critical understandings derived from the feminist critique of personal autonomy. A more nuanced understanding of personal autonomy, including the subtle social

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[9] At the level of moral reasoning, what is most pertinent to my arguments are the considerations which apply to determining whether to accept or reject a competent patient's refusal of treatment for an illness which appears to be impacting their cognitive capacities and value judgments, without rendering them mentally incompetent.

[10] *Starson v Swayze*, [2003] 1 SCR 722.

factors that moderate its expression, as well as the overt impacts caused by symptoms of mental illness, reveal the inadequacy of the law's predominant definition of autonomy as essentially "freedom from unwanted interference". A more developed theory of autonomy may justify a different approach to involuntary psychiatric treatment, which is discussed in the following section.[11]

4. The narrative approach to prescribing involuntary treatment

Lastly, I consider each of the preceding discussions together in theorizing how to optimally respect a person's autonomy when they are competent but suffering from a mental illness. In answering the thesis question of this work, I follow the narrative theory proposed by Craig Edwards and argue that an ethically defensible policy for treating competent psychiatric patients against their will consists in adhering to their stated treatment preferences which are most consistent with their personal narrative.[12]

5. Concluding Argument

Although it is beyond the scope of this work to suggest an exact formulation of law that would accomplish this end, I propose an example and discuss the rationale justifying the implementation of a limited form of psychiatric paternalism with respect to competent patients who refuse psychiatric treatment.

B. Note on Jurisdictional Comparisons

Rather than focus on only one Canadian jurisdiction in my discussion on Canadian law, I chose to examine all of them. This approach was taken because Canada's divergent approaches to involuntary psychiatric treatment can be usefully compared and contrasted in order to analyze the different philosophies underlying the treatment. Given that all Canadian jurisdictions' law must comport with the principles of the *Charter*, they are all subject to the same overarching framework of principles. As Terry Carney summarizes, the history, cultural values, and constitutional

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[11] I note that I am choosing to center this discussion on the various ethical values and principles, such as autonomy and paternalism, instead of focusing on the issue from the perspective or personal or civil rights. The rights discourse may serve only to obscure deeper concerns in this matter, as an appeal to "rights" may function as an absolute bar to further discussion. In any event, the discussion of rights is not strictly necessary, as many bioethicists take rights to be derivative off of other foundational concepts, such as personal autonomy, individual interests, or community membership. One can view rights as mere political constructs, useful as communicative tools used in advocating for and attaining the foundational precepts (personal autonomy, and the like) in many instances. Therefore, I prefer to address the "root" principles, rather than the rights constructs which supervene upon them. See eg Richard Ashcroft, "The Troubled Relationship Between Bioethics and Human Rights" in Michael Freeman, ed, *Law and Bioethics: Current Legal Issues 2008, Volume II* (Oxford, NY: Oxford University Press, 2008) 31 at 39-41.

[12] See Craig Edwards, "Beyond Mental Competence" (2010) 27 J Applied Philosophy 273.

structures in a given jurisdiction will shape its governing mental health legislation. Yet despite arguably similar normative values, cultures, and the same constitutional framework, Canadian approaches to involuntary psychiatric treatment differ dramatically. Overall, the liberal autonomy-centric values of the West tend to lend themselves to rights-based models, and this is true of several Canadian jurisdictions. However, there are contrasting jurisdictions which are predicated on a "health and safety" approach, functioning more paternalistically to protect both society and the patient "from themselves".[13]

The legalistic framework in mental health law in North America over the past 50 years can be described as a swing of the pendulum from medical paternalism,[14] which began with locating authority and highly discretionary decision-making power in the psychiatric establishment. At this point, whether a patient was subject to psychiatric treatment or not was almost entirely at the discretion of their attending physician and the patient had little or no input. This has shifted towards a patients-rights approach, where the authority to override a patient's decision is circumscribed and located in the law.[15] Interestingly, despite this overall shift in the locus of authority to provide psychiatric treatment, Canadian jurisdictions have adopted laws of implementing psychiatric treatment which are in themselves so diverse that they appear to replicate the evolution of mental health law instantaneously. That is, some jurisdictions maintain a more traditional paternalistic system wherein a diagnosis of mental disorder all but determines the issue of involuntary treatment, while others are more progressive and predicate treatment on the standard of mental competence of the patient to provide informed consent. Reviewing the approaches of these different jurisdictions offers insight into the goals and values that the law is aiming to advance in each case.

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[13] Although I will be focusing on Canadian jurisdictions which remain paternalistic, it must be noted that the more paternalistic "health and safety" approach exists among in a number of other common-law jurisdictions outside of Canada. Terry Carney, "Involuntary Mental Health Treatment Laws: The 'Rights' and the Wrongs of the Competing Models?" in Bernadette McSherry and Penelope Weller, *Rethinking Rights-Based Mental Health Laws* (Portland, OR: Hart Publishing, 2010) 257 at 259.

[14] The movement towards a patient rights-based approach coincided with the fruition of international human rights in the 1980's, in particular, with the advent of the *United Nations* See Penelope Weller, "Lost in Translation: Human Rights and Mental Health Law" in Bernadette McSherry and Penelope Weller, *Rethinking Rights-Based Mental Health Laws* (Portland, OR: Hart Publishing, 2010) 51; *Convention on the Rights of Persons with Disabilities* Convention on the Rights of Persons with Disabilities, adopted 13 December 2006, GA Res 61/106, UN Doc A Res/61/106 (entered into force 3 May 2008).

[15] See H Archibald Kaiser, "Canadian Mental Health Law: The Slow Process of Redirecting the Ship of State" (2009) 17 Health L J 139 at 142; Peter Carver, "Law and Mental Illness in Canada" in John C Irvine, Philip H. Osborne, and Mary J Shariff, eds, *Canadian Medical Law: An Introduction for Physicians, Nurses and other Health Care Professionals* 4th ed (Toronto: Carswell, 2013) at 295.

In the following section, I begin my analysis by defining the problem of involuntary psychiatric treatment of competent patients in concrete, tangible terms.

CHAPTER 2: Background Discussion on Key Concepts

A. Focus on Schizophrenia

As schizophrenia will be the primary subject of discussion throughout the balance of this work it will be useful to understand the particular facets of the condition which are relevant to the law and policy concerning its compulsory treatment. Accordingly, the following section outlines pertinent information about the background, diagnosis, and treatment of schizophrenia.

According to the *Diagnostic and Statistical Manual IV,* (DSM IV-TR) schizophrenia is a chronic mental illness which occurs on a spectrum with several sub-types, primarily characterized by disturbances in cognition or emotions, or disorganized speech or behaviour, which cause disruptions to the person's social or occupational functioning. The typical onset of symptoms usually occurs in the person's late teens and twenties.[16]

The illness has a significant prevalence rate, occurring in 1% of the world's overall population[17] and accounting for 2% of the disease burden in established market economies.[18] Recently, in 2013, the DSM IV-TR has been updated by the *Diagnostic and Statistical Manual V* (DSM V),[19] which has eliminated the diagnostic sub-type categories that existed in the DSM IV-TR.[20] Generally, diagnosis requires the presence of positive and/or negative characteristic symptoms for six months, which includes at least one month of active symptoms.[21] Positive symptoms include things like delusions, hallucinations, grossly disorganized speech, or catatonic behaviour. Negative symptoms include inappropriate or flattened affect, poverty of speech (alogia), or lack of motivation (avolition). Additional symptoms include social and occupational dysfunctions, such as disturbances in function at work, interpersonal relations, or self-care.[22] As

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[16] See American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*, 4th ed, text rev (Washington, DC: American Psychiatric Association, 2000) #295.1–295.3, 295.90.

[17] Laura Weiss Roberts et al., "An Inverse Relationship Between Perceived Harm and Participation Willingness in Schizophrenia Research Protocols" (2006) 163 Am J Psychiatry 2002.

[18] CJ Murray & AD Lopez, eds. *A Comprehensive Assessment of Mortality and Disability from Diseases. Injuries, and Risk Factors in 1990 and Projected to 2020* (Cambridge, Mass: Harvard University Press, 1996)

[19] American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*, 4th ed, text rev (Washington, DC: American Psychiatric Association, 2000); American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed (Arlington, VA: American Psychiatric Publishing, 2013).

[20] American Psychiatric Association, *DSM-5 Development*, online: American Psychiatric Association <http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf>.

[21] American Psychiatric Association, *DSM-5 Development*, online: American Psychiatric Association online: <http://www.dsm5.org/Documents/Schizophrenia%20Fact%20Sheet.pdf>.

[22] *Supra* note 16. (American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*, 4th ed, text rev (Washington, DC: American Psychiatric Association, 2000) #295.1–295.3, 295.90.)

noted, under the DSM-IV TR, schizophrenia diagnoses were based on clusters of symptoms, as it was thought that each could be treated differently.[23] These distinctions in symptom clusters were thought to be relevant for diagnostic and treatment purposes, but would also be relevant to the issue of decisional capacity assessment.[24] For instance, while a person suffering from severe schizophrenia-catatonic type might be easily declared incompetent due to their complete withdrawal from social interaction and inability to communicate, a person with schizophrenia-paranoid type may only have minor delusions and flattened affect, and therefore may retain much of their decisional capacity. The DSM V has eliminated these sub-types, as years of research in the intervening years since the DSM IV-TR was implemented has revealed the inherent unreliability and low validity of sharp categorical distinctions between clusters of symptoms, and their inefficacy in differentiating long term treatment response patterns. Instead, a dimensional approach will be implemented wherein the type and severity of symptoms are rated and treatment is tailored accordingly.[25] When considering the issue of competence to accept or refuse treatment it must be remembered that some symptoms of schizophrenia will be essentially determinative of the matter, such as in the case of catatonic symptoms, while others will have a far more variable impact, such as in the case of delusional, paranoid, or disorganized symptoms.

Crucially, the nature of some symptoms of schizophrenia are such that they impact the decision-making processes of a patient in ways which the patient themselves may not notice. This may be the case with paranoid or delusional symptoms, where the person may be prone to believe or perceive fantastic and verifiably false things, such as the belief that their minds are being read by government agents or aliens. One of the most problematic instances of this kind of symptom presentation is where the patient's perceptions and beliefs become distorted in a manner such that they do not believe that they have a mental illness at all and become adverse to treatment, preferring instead to live as they are. When a patient's perceptions and reasoning capacities become compromised in this way, they are said to lack "insight" into their illness, which, psychiatrically speaking, militates strongly towards a finding of incompetence to consent to or refuse treatment. One study found that between 50% and 80% of patients diagnosed with some

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[23] Five sub-types were identified: paranoid, catatonic, disorganized, undifferentiated, and residual.

[24] This is not to say that one's diagnosis was necessarily dispositive of their decisional competence, but generally speaking, it is reasonable to think that the presence of more severe symptoms would militate against a person's competence.

[25] *Supra* note 20.

form of schizophrenia do not believe they have a mental disorder.[26] It should be noted that the concept of "insight" in mental illness is controversial in itself, as some have argued that it, along with a number of other legally and psychiatrically irrelevant factors, serves to bias medical and legal practitioners towards undervaluing the actual decisional capacity of patients.[27]

B. Competence as a Key Clinical Concept

The concept of competence to consent to treatment is central to legal and philosophical inquiries concerning involuntary treatment of schizophrenia in the circumstances outlined above. In this brief section I discuss the prevailing clinical understanding of competence in the context of consent to medical treatment in order to facilitate later discussions in sections on law and philosophy.

In both the legal and ethical sense, the definition and assessment of competency is critical to determining how people suffering from mental disorders will interact with the mental healthcare system. Clive Unsworth has made the point that the "[l]aw actually constitutes the mental health system, in the sense that it authoritatively constructs, empowers, and regulates the relationship between the agents who perform mental health functions."[28] However, while the law gives authority to the mental healthcare system, the purposes and goals of the law and of the mental health system are divergent as the aim of law is to protect individual rights, while psychiatry's aim is to be responsive to the individual's (perceived) needs, and not their expressed wishes.[29] This tension between autonomy and paternalism is at the heart of the discussion concerning refusal of mental healthcare.[30] As will be discussed, in the context of healthcare treatment, the requirement

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[26] S Raffard, et al., "Lack of Insight in Schizophrenia: A Review. Part I: Theoretical Concept, Clinical Aspects of Amador's Model" (2008) 34(6) Encephale 597.

[27] See Ian Freckleton, "Extra-Legislative Factors in Involuntary Status Decision-Making" in Bernadette McSherry and Penelope Weller, *Rethinking Rights-Based Mental Health Laws* (Portland, OR: Hart Publishing, 2010) 203. Other extra-legislative factors which Freckleton argues are routinely illegitimately incorporated into competency assessments include: whether or not the patient is non-compliant with their medications, whether or not they are promiscuous or violent, whether or not they abscond from detention, whether or not they exhibit poor hygiene, impaired judgment, or suffer from a personality disorder. Whether or not a patient exhibits these traits in and of themselves ought not to bear on an assessment of their competency, and as a matter of fact, laws often prohibit such considerations in the course of the assessment, but Freckleton argues that there is discordance between what the law indicates and what practices actually occur in clinical practice.

[28] Clive Unsworth, *The Politics of Mental Health Legislation*, (Oxford: Clarendon Press, 1987) at 5.

[29] Margaret Somerville, *Death Talk: The Case Against Euthanasia and Physician-Assisted Suicide* (Montreal, QC: McGill-Queen's University Press, 2001) at 321.

[30] See Edmund Pellegrino and David Thomasma, *For the Patient's Good: The Restoration of Benficence in Health Care* (New York: Oxford University Press, 1988) at 29.

to obtain informed consent is regarded as an indicia or perhaps even an instantiation of the patient's autonomy. The three main elements in giving informed consent are: voluntary choice, disclosure of necessary information to make the decision, and competence to decide. Absent any one of these, consent is not valid, legally or ethically speaking.[31] Generally, that a decision be voluntary and informed is arguably more straightforward a determination than the competence of the decision maker, and certainly this bears out in the case of mental healthcare decisions.

For the most part it is uncontroversial to take the position that when a patient is competent their autonomy is given priority over their medical well-being and their treatment refusals are respected. Absent this mental competency, a court may exercise its *parens patriae* jurisdiction to provide for the care of those who cannot care for themselves, even against the person's objections.[32] Since the notion of competency lies at the base of the tension between the legal and psychiatric goals and priorities for the patient, it is necessary to discuss what exactly competence is.

Competence is often assessed when the presence of a mental disorder is suspected due to an abrupt change in a person's mental state. While a patient's mere disagreement with their healthcare professional ought not prompt a competency assessment Grisso and Applebaum argue that the assessments are warranted in the case of patients refusing treatment for mental disorders, chiefly due to the empirical reality that it is likely the mental disorder itself which is at least partially motivating the refusal.[33] Competency may be assessed either through a clinical interview or by using a structured assessment tool, such as the MacCAT-T, which is specifically designed to assess the aspects of competence discussed below.[34]

It is well established that the assessment of mental capacity is task-relative, context specific, and can vary over time. The concept of a global level of capacity is typically rejected in favour of a nuanced approach which reveals that a person can, for instance, be competent to

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[31] See Thomas Grisso & Paul S Applebaum, *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals* (New York, NY: Oxford University Press, 1998) at 6.

[32] See eg *Fleming v Reid* (1991) 4 OR (3d) 74 at para 45; *E (Mrs) v Eve*, [1986] 2 SCR 388 at 426; *AC v Manitoba (Director of Child and Family Services),* 2009 SCC 30, [2009] 2 SCR 181.

[33] Grisso and Applebaum, *supra* note 31 at 62-64.

[34] *Ibid* at 85, 105-125. For additional details on the assessment tool, see Thomas Grisso, Paul S Applebaum, and C Hill-Fotouhi, "The MacCAT-T: a clinical tool to assess patients' capacities to make treatment decisions" (1997) 48:11 Psychiatr Serv 1415.

consider and consent to some medical procedures but not others, or has the requisite capacity to manage their day to day functioning, but is not able to make complex medical decisions.[35]

Competence is a legal concept but it is quasi-legal in a sense, insofar as physicians, including psychiatrists, use the word to describe the mental state of a person when assessing their judgment for making decisions. It is a quasi-legal concept because the physician's (factual) assessment of the person's decision-making capacity may result in certain legal consequences—namely the person's deprivation of authority in making decisions for themselves. Decision making capacity is also a culmination of three separate concepts: cognition, emotion, and conation, some or all of which are affected by mental disease or defect in a manner requiring a psychiatric analysis, as opposed to a purely legal inquiry.[36] Commentators frequently distinguish between competence and capacity, the former being a legal concept, defined by statute, variably by jurisdiction, and the latter being a clinical concept, assessed based on personal expertise by using different assessment tools, which also results in some variation.[37] While capacity assessments are nuanced, the competency status of an individual tends to be an all-or-nothing label, where one is either competent or not, as opposed to "competent with respect to x but not y".[38]

According to Grisso and Applebaum, "[i]ncompetence constitutes a status of the individual that is defined by the *functional deficits* (due to *mental illness, mental retardation, or other mental conditions*) judged to be sufficiently great that the person *currently* cannot meet the *demands* of a specific decision-making situation, weighed in light of its potential *consequences*."[39] Just as there are three elements to informed consent (voluntariness, information, and competence), clinically speaking, competence is assessed on the basis of a person's capabilities in four areas: the ability to express a choice, the ability to understand information, the ability to appreciate the significance

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[35] Mona Gupta, "All Locked Up with Nowhere to Go: Treatment Refusal in the Involuntary Hospitalized Population of Canada" in Kate Diesfeld & Ian R Freckelton I (eds): *Involuntary Detention and Therapeutic Jurisprudence* (Burlington: Ashgate Publishing Limited, 2003) 155.

[36] See Irwin N Perr, "The Many Faces of Competence" in Walter E Barton & Charlotte J Sanborn, eds, *Law and the Mental Health Professions: Friction at the Interface* (New York, NY: International University Press, 1978) 211. See also Somerville, *supra* note 29 at 317. See also E-H W Kluge, "Competence, Capacity and Informed Consent: Beyond the Cognitive-Competence Model" 2005 24:3 Canadian Journal on Aging 295.

[37] See Grisso and Applebaum, *supra note 31*, at 11; Elyn R Saks, *Refusing Care: Forced Treatment and the Rights of the Mentally Ill* (Chicago: University of Chicago Press, 2002) at 177; James M Dubois, *Ethics in Mental Health Research: Principles, Guidance, and Cases* (New York, NY: Oxford University Press, 2008) at 79.

[38] This blanket understanding of competency can result either on a *de facto* basis after an assessment of mental capacity, wherein the patient's capacity is essentially reduced to a less precise finding of competence or incompetence, or may arise automatically on a *de jure* basis, such as, for example, in the instance where the law deems all minors to be incompetent without need for assessment. See Grisso and Applebaum, *supra* note 31 at 10-18.

[39] *Ibid* at 27. Emphasis in original.

of this information, and the ability to reason.[40] The ability to express a choice is a threshold issue, requiring communicative abilities.[41] The ability to understand information is variably impacted by intellectual deficiencies and mental impairments and illnesses, traumas, and the like, depending on how complex the relevant information is.[42]

The appreciation requirement refers to the ability of the person to relate the information to their own situation and is often contingent on the beliefs of the individual. For instance, a person might understand the nature of their illness or a proposed treatment but not appreciate or believe that they will deteriorate without treatment. This element of competence can be difficult to assess since it essentially involves an evaluation of the reasonability of the patient's beliefs or priorities in the circumstances. In one case, a refusal of treatment could be seen as reasonable, such as in the case of a patient's refusal of aggressive chemotherapy due to the horrendous side effects, while other refusals might give rise to a suspected lack of insight or appreciation of one's need for treatment.[43]

Lastly, the ability to reason refers to the process by which a person arrives at their decision. The person must be able to demonstrate a coherent structure of reasons for their decision, whatever it may be, which may involve assessment of their ability to consider multiple consequences or outcomes, evaluate the probabilities of each as well as their relative merit. A person who is single-minded in their reasoning, evidently overvaluing the likelihood of some outcomes over others, or becoming preoccupied with some factors of treatment (for example, a fear of needles or a single bad reaction to a drug) to the exclusion of considering significant benefits, may be assessed as incompetent.[44]

Frequently the patient's ability to understand and appreciate the circumstances of their illness and proposed treatment is referred to in the clinical setting as their level of insight. Ian Freckleton argues that while insight is a valid factor in assessing competence in theory, it is highly contextual, subjective, and difficult to define. As Freckleton explains, a medical practitioner's view of patient insight may consist of a number of factors, including recognition by the patient that they have a mental illness, acknowledgment that some symptoms are pathological, acceptance of treatment, recognition of symptoms when they occur, recognition of efficacy of treatment, acceptance of the

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[40] *Ibid* at 31-54; Dubois, *supra* note 37 at 80.
[41] Grisso and Applebaum, *supra* note 31 at 36.
[42] *Ibid* at 40.
[43] *Ibid* at 47-50.
[44] *Ibid* at 54.

need for modifications in lifestyle, and recognition of signs of a relapse and ability to act remedially. The problem, he explains, is that some patients may simply disagree, philosophically, with the definition of mental illness or the importance of treatment, based on their own priorities and values, and not necessarily on the basis of flawed reasoning.[45] In other words, assessments of insight may simply be assessments of patient values, which is to say that some assessments of insight are just paternalistic treatment clothed in terms of 'competency' or 'decisional capacity'.

The concept of insight is closely related to legal standards of competence which are implemented in clinical practice and legal proceedings. The challenges which Freckleton has raised from the clinical perspective illustrate the divergence between legal standards of competency assessment and actual clinical practice. This is not the issue I aim to address, though this phenomenon must be kept in mind as the examination of legal competency analyses and their outcomes proceeds. In any event, while not all patients refuse treatment based on a lack of insight, some do, and the challenge becomes which I aim to address in this work: defining when we may override such refusals.

C. <u>The Problem of Non-Compliance with Treatment</u>

In spite of these and other difficulties, psychiatric intervention has shown a significant degree of success in the treatment of schizophrenia, and so there is a significant motivation to facilitate treatment where possible. Short term studies have shown that approximately 70% of patients receiving standard treatment (consisting of a combination of pharmacotherapy and psychosocial therapy) will experience substantial or complete remission of symptoms within one year, albeit the symptoms can return in some cases.[46] Longitudinal studies have shown a wide margin of treatment outcomes, with between 20-65% of cases rated as "good"; and 20% rated as returning to a pre-morbid level of functioning, given proper adherence to treatment.[47] One of the greatest challenges in the treatment of schizophrenia is the substantial degree of non-compliance with pharmacotherapy, where patients either fail to adhere to their prescribed medication regimen or simply discontinue it altogether. Some studies indicate that the non-compliance rate can be as low

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[45] *Ibid* at 208.

[46] Michael S Ritsner, *Handbook of Schizophrenia Spectrum Disorders, Volume III: Therapeutic Approaches, Comorbidity, and Outcomes* (Dordrecth, NY: Springer, 2011) at 3.

[47] *Ibid*.

as between 42% and 50%.[48] A number of reasons for non-compliance with medication for the treatment of schizophrenia have been identified and studied, including for instance, the fact that the patient runs out of medication, they think the medication was not needed (because they lack insight and deny that they are suffering from a mental illness), they do not want to take it because they think it won't work, or they fear its side effects.[49]

Such non-compliance is frequently associated with poor clinical and non-clinical outcomes, including harms and burdens to the patient which include symptom relapse and re-hospitalization. In addition to the direct health burdens of their symptoms, there are also non-health costs such as the loss of one's employment, family, or ability to live independently, either on a short of long term basis. As well, there are increased health care, social, and economic costs to others that are closely involved with individuals who exhibit poor medication compliance.[50] Due to the high levels of non-compliance and the resulting symptom relapse, patients may experience unnecessary hardship in their family life. The health care system will also experience increased burden as attempts are made to re-initiate therapy and return the patient to their symptom free or symptom-reduced state.

In the meantime, before or between periods of receiving treatment, people suffering from symptoms relating to schizophrenia are more likely to face co-morbidities and other related health risks. There is an increased risk of suicide when a person discontinues their medication abruptly, periods of untreated psychosis may precipitate a worsening of the prognosis of their illness overall, and uncontrolled cessation of medication is associated with more severe withdrawal effects.[51] There is also evidence that people suffering from schizophrenia, especially during phases where they are not undergoing treatment, are at an increased likelihood to suffer from various physical illnesses. Infectious illnesses, in particular, HIV infection, have been found to correlate higher in the population of people with schizophrenia than the general population, mainly due to increases

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[48] Joyce Cramer & Robert Rosenheck, "Compliance With Medication Regimens for Mental and Physical Disorders" (1998) 49:2 Psychiatric Services; DO Perkins, "Predictors of noncompliance in patients with schizophrenia" (2002) 63:12 Journal of Clinical Psychiatry 1121.

[49] C Cooper et al., "Why people do not take their psychotropic drugs as prescribed: results of the 2000 National Psychiatric Morbidity Survey" (2007) 116 Acta Psychiatr Scand 47.

[50] Franca Centorrino et al, "Factors Associated With Noncompliance With Psychiatric Outpatient Visits" (2001) 52:3 Psychiatric Services 378.

[51] MA Aldridge, "Addressing Non-Adherence to Antipsychotic Medication: A Harm-Reduction Approach" (2012) 19 Journal of Psychiatric and Mental Health Nursing 85 at 89-91.

in risk-taking behaviour, both in terms of unsafe sexual practices and increased substance abuse.[52] Another reason that people suffering from schizophrenia experience more and worse physical illnesses than the general population is the increased likelihood of failing to seek medical attention for their illnesses during periods of mental instability.[53] For instance, a person with schizophrenia who also suffers from diabetes may neglect to take their insulin, or may lack the wherewithal to recognize or seek treatment for a newly acquired hepatitis infection.

D. The Problem Caser of Chronic Cyclers

Of particular importance for the remainder of this work is the phenomenon of what I refer to as "chronic cyclers" in the context of schizophrenia. These are people who are suffering from schizophrenia who repeatedly cycle through stages of compliance and non-compliance with their medication. They may discontinue their medication either because of the undesirable impact or fear of side-effects, or because some of their symptoms actually manage to break through the medication and cause various behavioural abnormalities. Without treatment the person's mental condition deteriorates, but often the process is gradual, leaving them with enough ability to evade re-admission to hospital and in any event, leaving them competent enough to refuse medical treatment, albeit that they become increasingly impaired over time. Sometimes the positive symptoms of the illness, such as the presence of delusions, may feed the patient's refusal of medication, increasing their resistance to attempts to resume their medication regimen. Other times the patient may have just had a change in mind or change in priorities, thinking that they do not need the medication any more or that the side effects are too much to bear. Eventually, however, their condition worsens to a point where they can be re-admitted to the hospital on grounds that they represent a danger to themselves or others, or they are otherwise so impaired that they can be declared as incompetent to refuse treatment. After a period of treatment within the institution, their symptoms lessen, they regain their mental capacity, and can be discharged, only to start the cycle over.

Given the variable nature and intensity of the symptoms of schizophrenia which a patient may experience when they discontinue their medication, one problem which is faced in the effort to

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[52] S Leucht et al, "Physical Illness and Schizphrenia: A Review of the Literature" (2007) 116 Acta Psychiatr Scand 317 at 319. See also M S Swartz et al., "Violence and Severe Mental Illness: The Effects of Substance Abuse and Nonadherence to Medication" (1998) 155:2 Am J Psychiatry 226.

[53] *Ibid.*

restore the patient to a pre-morbid state is that they often remain competent to refuse treatment for some period of time. While it is less ethically and legally problematic to override a treatment refusal if and when they are determined to be incompetent, it may take time for the patient to deteriorate to the point where they could be assessed as incompetent, during which they may expose themselves or others to various risks and dangers. Moreover, some jurisdictions may permit refusals of treatment even by incompetent patients.[54]

As discussed, the rate of non-compliance with medication in the context of schizophrenia is high, and the consequences thereof for both the patient and those close to them can be substantial. We therefore have some motivation to ascertain whether and under what conditions it would be permissible, ethically and legally, to intervene and ensure compliance with therapy, against a patient's wishes, while they are still competent, yet impaired and deteriorating—that is, when they are on the downward slope of a non-compliance cycle, prior to incompetence. This would enable proactive treatment to minimize the deterioration and harm to the patient, as well as reduce the burden on the patient's support network and the health care system at large; however, it would come at a cost of increased medical paternalism and arguably decreased patient autonomy, albeit that it is autonomy in the context of mental impairment.

The following section of this work outline the different approaches which have been adopted in Canadian law for providing involuntary psychiatric treatment. This will provide the legal context for the difficulties in dealing with "chronic cyclers" as well as other cases of marginally competent individuals who are at risk of harm due to the influence of their mental illness due to the moderation of their views on psychiatric treatment by the illness itself.

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[54] Notably, in Quebec, the *CCQ* art 16 provides that even an incompetent patient can categorically refuse non-emergency treatment. A court order is then required before treatment can be initiated.

CHAPTER 3: The Law of Involuntary Psychiatric Treatment in Canada

A. Introduction

As is the case with the law concerning delivery of health in Canada generally, mental health law is governed by statutes within each province, each of which in turn must comport with rights guaranteed by the *Charter*. Notwithstanding this, there is a significant degree of latitude in approaches between provinces in the implementation of involuntary treatment of mental illness. These differences will be discussed below however it must be noted first that in spite of variations in ground level principles,[55] all provincial statutes function similarly at an organizational level as they establish two distinct but related processes to concerning the treatment of mental illness—a process governing involuntary committal or detainment, and a process governing involuntary treatment.

A number of models of mental health legislation exist, but as Ambrosini points out, the "custodial" model is arguably the most prolific and conducive to legislative regulation. This model promotes various regulatory measures which typically enable peace officers to, in certain circumstances, take a person with a mental illness into custody, either based on their own authority or on the directive of medical professionals. Ambrosini argues that the problem with such an approach is that taking custody of patients, whether for their own good or the protection of others, takes the onus and motivation for capacity, self-direction, and self-actualization away from the mentally ill person, as they begin to believe that the authorities will be responsible for their welfare from now on.[56] This model is, by and large, characteristic of Canadian mental health legislation, perhaps out of necessity, since it is difficult to legislate other models of mental health treatment.[57]

For the purposes of this work, the most significant aspect of mental health legislation in Canadian jurisdiction concerns the requirements and procedures concerning consent and refusal

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[55] By "ground level principles" I refer to those which form the operational substance of legislative schemes, including for instance, provisions concerning the standards of competence to make medical decisions, particular approaches to implementing coercive treatment, provisions outlining who can consent to treatment on behalf of someone else, factors which must be considered by substitute decision makers, etc.

[56] Daniele Lamberto Ambrosini, *Psychiatric Advance Directives, Autonomy and Choice: An Interdisciplinary Perspective from Law, Ethics, and Medicine* (PhD Thesis, McGill University Department of Psychiatry, 2011) at 207 [unpublished].

[57] *Ibid* at 206-211. Other models of mental health treatment lend themselves better to clinical theory or institutional policy, such as, for instance, the "medical/biological model", which emphasizes diagnosis and treatment of mental illness just like any other somatic illness. But this approach is also be criticized for presuming a mechanistic and overly simplistic view of mental illness. In contrast, "consumer choice" models place emphasis on patient input, encouraging the formation of advance directives and substitute decision mechanisms maximally controlled by the patient, thus encouraging preventative action. See Ambrosini, *ibid* at 207, 209.

of consent to psychiatric treatment. This section will focus on the law which is most relevant to the involuntary treatment of competent patients, since it is this law which pertains to the unfortunate situation of the non-compliant chronic cycler described in the previous section.

B. Involuntary Admission: The First Step

Some preliminary matters of involuntary admission must be addressed to give context to the processes and principles surrounding involuntary treatment. The process of involuntary detainment or admission to a mental health institution is a necessary first step as it provides an opportunity to assess the person's condition and mental healthcare needs. Each of the provincial statutes in Canada address similar procedural and substantive issues in creating a regime governing involuntary admission to psychiatric facilities. Most legislation provides for review mechanisms relating to decisions regarding committals and treatment, thereby reducing legal oversight and instead appointing review bodies to adjudicate challenges and ensure proper adherence to substantive and procedural requirements.[58] Also common to all of the provincial statues are a series of thematic provisions which serve to limit the scope of applicability of the statute's involuntary admission or committal powers. These limiting themes include:[59]

i) Defining "mental disorder". Each statute requires that a person be suffering from a recognized mental disorder in order for the compulsory provisions within it to apply to them. By defining mental disorder more or less precisely, the scope of who is subject to it will contract or expand, respectively.

ii) The notation of the requirement that the person with the mental disorder actually requires treatment for it. If experts do not think a person requires treatment for their condition, the compulsory provisions of the statute will not apply.

iii) Some type of harm criteria which further circumscribes who can be subject to compulsory committal. It is most often required that the person represent a harm or potential harm to themselves or others in order to be subject to the compulsory provisions, or else they must be at a substantial risk of physical or mental deterioration if treatment is not received.[60]

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[58] See Joaquin Zuckerberg, "Jurisdiction of Mental Health Tribunals to Provide Positive Remedies: Application, Challenges, and Prospects" (2012) 57 McGill L J 267; Carver, *supra* note 15 at 298.

[59] See Carver, *ibid* at 300-305.

[60] See eg *Mental Health Services Act*, SS 1984-85-86, c M-13.1, s 2(a). Mental health legislation must set out standards of dangerousness and cannot leave the determination of dangerousness to medical judgment, albeit that the definition can involve some leeway in how much harm is required to permit involuntary detention in a psychiatric facility. See

iv) Notation that the person in question is not a suitable voluntary patient. This type of provision exists to emphasize that if the person is competent, not imminently dangerous, and otherwise willing to seek treatment, compulsory powers ought not to be applied to them.

v) Provisions outlining the requirement that the person be incompetent to consent to treatment, often expressed as lacking mental capacity.[61]

After the preliminary issue of admission is settled and the person's mental health status is assessed, the statutory regime provides a structure for facilitating involuntary treatment. The statute will set out the circumstances in which a person who is determined to be subject to compulsory committal may refuse treatment for their mental disorder. These provisions specify standards of competency, which, actions may be undertaken without consent of the patient, as well as structuring a decision-making process in the event of decisional incapacity. Most jurisdictions empower independent mental health tribunals to adjudicate on matters of appeals concerning both committals and compulsory treatment orders, as well as ensure institutions' adherence to requirements established in mental health legislation.[62] In the following section I will summarize the approaches of pertinent law in each province which govern involuntary committal (most often referred to as "involuntary admission") and treatment.

C. Canadian Law on Involuntary Treatment

1. Applicability of Canadian Common Law and the Canadian Charter

Before discussing the specific approaches to compulsory mental health treatment in each Canadian jurisdiction it is necessary to understand the impact of Canada's common law principles as well as the *Charter* on health law generally, particularly concerning matters of consent to treatment. Practically speaking, these principles translate to a guarantee of personal autonomy in medical decision-making, enshrining the well-entrenched common law right to be free from medical treatment without consent.[63]

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eg *Thwaites v Health Sciences Center Psychiatric Facility* (1988) DLR (4th) 338 (Man. CA); *McCorkell v Riverview Hospital* (1993), BCJ No 1518 (BCSC). While these decisions only have binding force in Manitoba and British Columbia respectively, it is arguable that the lack of contrary case law indicates that statutory definitions of the harm criteria are required across Canada, in lieu of leaving the determination entire to the judgment of a medical practitioner. See Carver, *supra* note 15 at 304.

[61] As will be discussed, some provinces do not implement a capacity requirement for committal criteria, as it is presumed that patients who qualify for compulsory commitment also lack the capacity to consent to treatment.

[62] See Zuckerberg, *supra* note 58.

[63] See *Fleming v Reid supra* note 32 at 31; *Malette v. Shulman* (1990), 72 OR (2d) 417, 67 DLR (4th) 321.

In terms of common law principles, a number of seminal cases reflect the development of a highly individualistic notion of personal autonomy in respect of medical treatment. In *Malette v Shulman,* the Ontario Court of Appeal had determined that a doctor who administers treatment contrary to a patient's stated wishes thereby commits a battery against their patient, notwithstanding that the treatment was medically prudent, completely successful, or even life-saving.[*64*] In arriving at this conclusion, Justice Robins held that "the right to determine what shall be done with one's own body is a fundamental right in our society. The concepts inherent in this right are the bedrock upon which the principles of self-determination and individual autonomy are based. Free individual choice in matters affecting this right should, in my opinion, be accorded very high priority."[65]

Similar reasoning prevailed at the Supreme Court of Canada in *Ciarlariello v Schacter*, with the well-cited passage reading:

> It should not be forgotten that every patient has a right to bodily integrity. This encompasses the right to determine what medical procedures will be accepted and the extent to which they will be accepted. Everyone has the right to decide what is to be done to one's own body. This includes the right to be free from medical treatment to which the individual does not consent. This concept of individual autonomy is fundamental to the common law. [66]

Developing along with the common law, there has been a significant body of jurisprudence considering medical decision-making in relation to the *Charter*. Various *Charter* rights are at stake when a psychiatric treatment decision is being deliberated. For instance, committals can, if improperly executed, contravene an individual's right to liberty (section 7) and right to freedom from arbitrary detention (section 9). Improper involuntary treatment may also run afoul of the individual's right to security of the person (section 7) and the guarantee against cruel and unusual punishment (section 12). When such impingements on individual rights takes place in a discriminatory way, such as on the basis of having a mental disorder, the individual's right to equal treatment before and under the law may also be violated (section 15).[67] Acknowledging the broad application of the *Charter*, the most prominent principled arguments to occur in cases relating to involuntary treatment undoubtedly concern section 7, therefore I will confine my analysis to this

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[64] *Malette v Shulman, ibid*.

[65] *Ibid* at para 41.

[66] *Ciarlariello v. Schacter,* [1993] 2 SCR 119 at para 40 [*Ciarlariello*].

[67] Carver, *supra* note 15 at 294.

provision. Section 7 of the *Charter* states that "[e]veryone 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."[68]

One of the earliest cases in which personal autonomy *vis a vis* medical procedures was addressed was *R v Morgentaler*.[69] Commenting on then-present barriers to access to abortion services, Justice Wilson of the Supreme Court of Canada found that "the right to liberty contained in section 7 guarantees to every individual a degree of personal autonomy over important decisions intimately affecting their private lives."[70] According to Justice Wilson, the autonomy which is protected by section 7 is proximate to the notion of agency and the ability for a person to freely choose one's priorities in life, as well as the medical treatments which concern them. Though her opinion was one of several concurring in the result of the case, she was the only member of her panel to discuss the issue in terms of autonomy rights. Her opinion, however, is arguably the most cited in subsequent cases. Elsewhere the Supreme Court has affirmed that section 7's guarantee of "liberty" is engaged where state compulsions or prohibitions affect important and fundamental life choices"[71]

Charter jurisprudence in respect of medical treatment, particularly where the rights under section 7 are concerned, has focused on describing *Charter* protections as providing freedom from unwanted interference with one's body or choices in respect of it, thus characterizing it more as a negative right than as a positive right.[72] This is not surprising, since the cases which invoke section 7 tend to concern a contention over who is authorized to make medical decisions for the patient in question, which often reduces to a question of whether or not the patient's own preferences are to be respected. For instance, in *Fleming v Reid* the Ontario Court of Appeal had to determine whether or not a patient's prior competent refusal of treatment (anti-psychotic medication) could be overridden by appeal to the review board once the patient had become incompetent due to a deterioration in their mental health status.[73] Answering this issue in the negative, Justice Robins emphasized that

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[68] *The Charter*, *supra* note 1, s 7.

[69] *R v Morgentaler*, [1988] 1 SCR 30.

[70] *Ibid* at para 240.

[71] *Blencoe v British Columbia (HRC)*,[2000] 2 SCR 307 at para 49.

[72] By contrasting negative and positive rights, I mean to note the difference between negative rights against interference versus positive rights to aid or assistance, for instance, to be guaranteed a certain standard of care, etc.

[73] *Fleming*, *supra* note 32.

> The right to determine what shall, or shall not, be done with one's own body, and to be free from non-consensual medical treatment, is a right deeply rooted in our common law…. With very limited exceptions, every person's body is considered inviolate…. The fact that serious risks or consequences may result from a refusal of medical treatment does not vitiate the right of medical self-determination.[74]

Among his reasons for finding that the provisions which enabled the physician to override the competent wishes of the plaintiff were contrary to section 7 of the *Charter,* Justice Robins linked the common law principles with the *Charter*, holding that "[t]he common law right to bodily integrity and personal autonomy is so entrenched in the traditions of our law as to be ranked as fundamental and deserving of the highest order of protection."[75]

Another notable case addressing the issue of *Charter* rights in the medical context is *Rodriguez v British Columbia (Attorney General)*, where the prohibition on assisted suicide in Canada was narrowly upheld by the Supreme Court of Canada.[76] Justice Sopinka emphasized that personal autonomy, guaranteed under section 7 of the *Charter*, includes "at the very least, control over one's bodily integrity free from state interference and freedom from state-imposed psychological and emotional stress."[77] This freedom, conceived of as a negative right—to be free from unwanted interference, is viewed as an instance of the right to "security of the person".[78] However, in spite of this strong endorsement of freedom from interference, Justice Sopinka held that individual autonomy interests are not absolute and must be balanced against state and public interests, which in the case of assisted suicide, favoured upholding the prohibition in order to guard against possible abuses.[79]

To summarize, the Canadian *Charter* as well as the existing body of common law concerning the requirement for consent to medical treatment, demonstrates a strong commitment to protecting individual autonomy, constructed in the negative sense, that being a right against unwanted interference.[80] Failure to obtain proper informed consent before administering medical treatment can give rise to an action in battery. Statute law must comport with the negative freedoms

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[74] *Ibid* at para 33 [Emphasis added].

[75] *Ibid* at para 41.

[76] *Rodriguez v British Columbia (Attorney General),* [1993] 3 SCR 519 (*Rodriguez*).

[77] *Ibid* at paras 136.

[78] Justice Wilson located autonomy in medical decision-making in the right to liberty as well.

[79] *Supra* note 76 at para 146.

[80] For instance, in In *AC v Manitoba (Director of Child and Family Services)*, *supra* note 32 at paras 39-40, a majority of Supreme Court of Canada held that the "tenacious relevance in our legal system of the principle that competent individuals are — and should be — free to make decisions about their bodily integrity … When competency is not in question, this right to "decide one's own fate" entitles adults to direct the course of their own medical care."

guaranteed by section 7 of the *Charter*, which the courts have indicated can be done by predicating involuntary treatment (i.e. treatment without consent) on, among other things, a lack of competence to consent.[81] Notwithstanding these clear autonomy-centric principles which have been established through interpreting the *Charter* and the common law, each Canadian jurisdiction has taken its own approach to legislating involuntary treatment of mental illness, and regional variations tend to reflect variable political, social, and cultural values.[82] These will now be discussed in detail.

2. Canadian Statute Law Pertaining to Involuntary Psychiatric Treatment

In line with the aforementioned cases and *Charter* principles, there are four overarching statutory frameworks which comprise Canadian law on involuntary psychiatric treatment. I describe them below, grouping them under headings based on how each framework is moderated by the mental competence of the patient in question.[83] Each approach will be discussed in turn.

i. *The Issue of Competence in Treatment Refusals is Moot in Light of Statutory Architecture*

Four Canadian jurisdictions pre-emptively preclude the concern of treating competent patients against their objections by addressing the matter indirectly through their involuntary admission criteria. That is, once admitted as an involuntary patient, the patient is deemed to lack capacity to consent to treatment in any case. There is a subtle difference between how each jurisdiction operates.

In Newfoundland, Saskatchewan, and Nova Scotia, the issue of providing involuntary treatment to competent patients is moot since the patient's capacity to consent to treatment is simultaneously decided by the criteria for involuntary committal to mental health facility. The criteria for involuntary admission expressly stipulates that the person must lack the capacity to make treatment decisions.

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[81] The relationship between involuntary treatment legislation,the *Charter,* and the mental competence of the patient will be discussed below in detail within the discussion on the case of *Starson v Swayze*, *supra* note 10.
[82] See Ambrosini, *supra* note 56 at 206.
[83] See Carver, *supra* note 15**.**

Saskatchewan

Saskatchewan's *Mental Health Services Act* indicates that an involuntary admission certificate must state that the person in question is suffering from a mental disorder requiring treatment provided by the given in-patient facility.[84] The standard of competency is also established in this provision since involuntary admission requires that the person cannot, in light of their mental disorder, fully understand the information necessary to make treatment decisions. While this definition of capacity is less precise than is typical in Canadian legislation, supplementary legislation defines capacity to include not only the necessary level of understanding, but also criteria of appreciation and ability to communicate a decision.[85]

Newfoundland and Labrador

Substantially similar wording of the requirements for involuntary admission to a psychiatric facility are present in Newfoundland and Labrador's *Mental Health Care and Treatment Act.*[86] There is no explicit definition of mental capacity in this Act, however, the requirements appear consonant with the "understand and appreciate" standard of other Canadian jurisdictions as it remains a requirement for involuntary admission that the person, as a result of their mental disorder, "is unable to fully appreciate the nature and consequences of the mental disorder or to make an informed decision regarding his or her need for treatment or care and supervision…".[87]

Nova Scotia

Nova Scotia's *Involuntary Psychiatric Treatment Act* mandates that involuntary admission can only occur when a person is suffering from a mental disorder and where they have already caused themselves or others serious harm or are likely to do so, or are likely to substantially deteriorate mentally or physically, and where they lack the capacity to make treatment decisions.[88] This legislation also defines capacity in great detail, exemplifying the typical approach to capacity assessments in Canada overall, wherein the person is assessed for their ability to understand

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[84] *Mental Health Services Act*, *supra* note 60, s 24(2)(a).

[85] *Health Care Directives and Substitute Health Care Decision Makers Act,* SS 1997-2000-04 c H-0.001, s 2(1).

[86] *Mental Health Care and Treatment Act,* SNL 2006, cM-9 1, s 17(b).

[87] *Ibid*.

[88] *Involuntary Psychiatric Treatment Act*, SNS 2005, c42, s 17.

information relevant to the treatment, the nature and purpose of the treatment, and the risks and benefits of accepting or refusing it.[89]

In summary, these three jurisdictions predicate involuntary treatment on involuntary admission, which in turn rests on, among other things, the capacity of the individual with the mental disorder. If they have the requisite capacity as defined in each of the Acts, they cannot be involuntarily admitted and therefore cannot be treated against their will either. If they lack this capacity, however, they may be eligible for involuntary admission and eligibility for involuntary treatment is entailed by this admission. This approach to legislating mental health treatment has one obvious merit and one obvious corresponding flaw. On the one hand by declining to detain people who are competent to refuse treatment, the problem of "warehousing" people with mental illness without providing treatment is avoided since everyone who can be detained (against their will) can also be treated, hopefully improving their condition and enabling their return to independent living. On the other hand, with capacity being the sole deciding factor in whether or not a person can be committed and treated, the system will not permit committals nor treatment of those who are potentially dangerous to themselves or others if they are found to possess the requisite decisional capacity.[90] Despite this "all or nothing" approach to admission and treatment, since treatment ultimately turns on whether or not the individual has the capacity to make treatment decisions, the result is the same as in other Canadian jurisdictions—namely, that competent individuals cannot be treated against their will.

Similar in the result to the previous three jurisdictions, in British Columbia a patient's involuntary patient status negates their right to refuse treatment. The difference is that in British Columbia, there is a *presumption* of a lack of mental capacity to consent to psychiatric treatment for involuntary patients, rather than a *requirement* for it for eligibility for involuntary admission and treatment.

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[89] *Ibid*, s 18(1).

[90] Carver, *supra* note 15 at 314. Of course, even where capacity is not yet ascertained or where it is believed that the person indeed has the requisite capacity to refuse admission, if they represent an imminent and/or serious risk of harm to themselves or others, there exist separate powers in the relevant legislation for a temporary apprehension and detention pending an examination. For instance, see Saskatchewan's *Involuntary Psychiatric Treatment Act,* sections 8 and 17, *supra* note 60. However, once the imminent danger passes, the person may be released without treatment only to suffer a later relapse and potentially harm themselves or someone else.

British Columbia

Very strong consent-oriented values and principles are established in British Columbia's *Health Care (Consent) and Care Facility (Admission) Act.*[91] The only exceptions to the requirement of obtaining informed consent for psychiatric treatment is in the case of emergencies, when acting on the directives of appointed substitute decision makers, or when the treatment involves minor healthcare issues at a time when consent cannot be obtained.[92] Crucially, these guarantees do not apply to involuntary psychiatric patients. British Columbia is arguably the most extreme in its approach to treating involuntary psychiatric patients as it does not provide for any right to refuse treatment once a patient has been admitted under involuntary status. Its *Mental Health Act* permits involuntary patients to be treated if such treatment is authorized by the director, as the patient's consent is deemed given in those circumstances by the Act.[93] There is no requirement to actually obtain it from the patient themselves. To be admitted as an involuntary patient, an examining physician must issue a certificate which states that the person has a mental disorder, that they require treatment in the given facility to prevent physical or mental harm or deterioration to themselves or others, and that they are not suitable as a voluntary patient.[94] It is notable that the harm criteria which is needed in order for the involuntary provisions to apply in British Columbia, that being a risk of harm to the patient or others or a risk of physical or mental deterioration without treatment, are similar to the harm criteria in other Canadian jurisdictions.

To summarize, all four jurisdictions – Newfoundland, Nova Scotia, and Saskatchewan, and British Columbia, render the issue of treating competent patients against their will moot, but they do so in slightly different ways. In the former three jurisdictions, the statutory requirements for involuntary admission and treatment are "all-or-nothing" and "top-down" in a sense, since the patient can only be admitted and treated if they lack the capacity to make treatment decisions and meet the requisite risk-of-harm criteria ("harm criteria"). British Columbia achieves a similar result in that admission and treatment can be "all-or-nothing", but it achieves this in a bottom-up manner, focusing solely on the harm criteria for involuntary admission and subsequently presuming consent for treatment on the part of such involuntary patients.

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[91] *Health Care (Consent) and Care Facility (Admission) Act,* 1996 RSBC c 181, ss 3-5.

[92] *Ibid*, ss 14-18.

[93] *Mental Health Act*, RSBC 1996 c288, ss 31, 22.

[94] *Ibid*, ss 22.

ii. *The Patient Autonomy Approach: Competent Patients Can Refuse Treatment Absolutely*

The jurisdictions within this subsection distinguish involuntary admission from involuntary treatment, permitting the former when the individual satisfies the relevant harm criteria, and the former only when the individual is not competent to consent to treatment. Competent patients may be admitted on an involuntary basis but cannot be involuntarily treated.

Ontario

Among Canadian jurisdictions, Ontario's legislation has arguably received the most academic attention, has been subject to the most controversy, and has been most reviewed by the courts. Mental health care in Ontario is governed by the *Mental Health Act*,[95] with additional provisions contained in the *Health Care Consent Act* that are particularly relevant to involuntary treatment.*[96]* Together these Acts create a comprehensive framework of procedures and protections involved in treating patients with a mental illness.

The statutes, in particular the *Health Care Consent Act*, now follow the principles established by the Court of Appeal's decision in *Fleming v Reid.* Simply put, the right to refuse treatment is a matter of competence, contrasting with the requirements for involuntary admission to a psychiatric facility, which is based on harm criteria and a perceived need for committal to assuage safety concerns for the patient or others.

While involuntary admission is governed based on the standard harm criteria, which includes risk of actual harm or significant deterioration on the part of the patient is dealt with under Ontario's *Mental Health Act*,[97] it is the *HCCA* which is most pertinent to determining when an involuntary patient can be subject to psychiatric treatment. The capacity or competence of the patient is the paramount consideration in determining if and how the patient will receive treatment for their illness. Capacity is not defined in Ontario's *Mental Health Act*, but the definition is taken from the *Health Care Consent Act*, along with numerous provisions relating to consent to treatment. Accordingly, the *HCCA* specifies that "[a] person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable

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[95] *Mental Health Act*, R.S.O. 1990, c. M.7.

[96] *Health Care Consent Act, 1996* SO 1996, c2 [*HCCA*].

[97] *Supra note 95*, s 20(5).

consequences of a decision or lack of decision".[98] It will be convenient to refer to this criterion of capacity as the "understand and appreciate standard". Notably, the *HCCA* creates a presumption of capacity absent reasonable grounds for belief to the contrary.[99]

Since the province has elected to legislate on the topic of consent to medical treatment generally rather than make special provisions for mental health treatment, it is within the context of the *HCCA*, as opposed to the *Mental Health Act* itself, that the law on involuntary treatment of mental illness is defined. First and foremost, there can be no treatment for any illness without the consent of the patient, or if they are determined to be incapable of giving consent, consent must be obtained from their appointed substitute decision maker.[100] It is also explicitly acknowledged that capacity is a variable phenomenon, wherein a person may be competent to consent to some treatments and not others, and may be competent at some times and not others.[101] The only exception to the requirement to obtain informed consent is in the case of emergency, where the patient is "experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm".[102] When the competence of a patient to consent to treatment is a contested issue, either the patient or the examining physician can apply to the Consent and Capacity Board, an external panel empowered by the *HCCA*, for a review of all pertinent information and ruling on the competence of the given patient.[103] Appeals may be taken from decisions of the Consent and Capacity Board to the Court. In the case where an objecting patient refuses treatment, the Court may make an order permitting treatment if it finds the Board has erred, and such treatment can commence prior to the final disposition of the treatment if the Court finds that it is in the patient's best interests to proceed with it.[104]

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[98] *HCCA*, *supra* note 96, s 4(1).

[99] *Ibid*, s 4(2), (3). In respect of healthcare, Ontario's *HCCA* includes possesses the most comprehensive provisions concerning the nature, scope, and procedures concerning consent of all the Canadian jurisdictions, even going as far to specifically state the requisite elements of informed consent. See *HCCA*, ss 11, 12, 14. The elements of consent established in the *HCCA* include the requirements that he consent relate to the treatment, it must be informed, be given voluntarily and must not be obtained through misrepresentation or fraud.

[100] *Ibid*, s 10.

[101] *Ibid*, ss 15, 16.

[102] *Ibid*, ss 18(4), 25(1).

[103] *Ibid*, ss 18.

[104] *Ibid*, s 19. Numerous provisions outline the procedures which must be followed in the appointment and decision making process of substitute decision makers. In all events, a substitute decision maker can only make treatment decisions for the patient once the patient is incompetent, and even then, such decisions must correspond with the patient's prior known wishes, or failing the availability of such information, by taking account of their best interests. See *HCCA,* ss 20, 21.

The *Starson* Case

The Supreme Court of Canada considered the standards applied by the Consent Board and reviewing courts in the case of *Starson v Swayze*, which involved interpretting the definition of mental competence in the context of involuntary psychiatric treatment.[105] In *Starson*, the legal issue was the interpretation of section 4(1) of Ontario's *HCCA,* which concerned the definition of competence in the context of consent to treatment. Scott Starson suffered from bipolar disorder and had been charged but found not criminally responsible for uttering death threats. While he was a gifted physicist, his personality was extremely unstable and his condition had deteriorated in recent years to the point where he periodically suffered from delusions. As Starson was considered a danger to himself or others due to his uttering threats as well as the presence of several paranoid delusions, he was involuntarily admitted to a psychiatric institution on the basis of satisfying the harm criteria of the *Mental Health Act*. His physician sought to medicate him but Starson categorically refused and his competency to do so was challenged, resulting in an appeal to the Consent and Capacity Board (CCB) for a final determination of his competence to consent to treatment.

The CCB found Starson incompetent and Starson appealed to the Ontario Superior Court, and the case was subsequently considered at the Supreme Court of Canada.[106] The Supreme Court was split but the majority held that, based on the facts concerning Starson and the relevant provisions of the *Health Care Consent Act*,[107] he was indeed competent to refuse the proposed psychiatric treatment. Notable is that fact that even the minority decision, which agreed with the CCB that Starson ought to be considered incompetent, still emphatically stated the importance of the values at stake which are enshrined in the *HCCA*, those being a balance between respecting personal autonomy in treatment decisions and providing treatment to those suffering from a mental impairment. The majority found that when the two values are in conflict, respect for personal autonomy must prevail even when the health consequences are dire, and that mental illness cannot be conflated with incompetence in order to justify overriding someone's autonomy.[108]

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[105] *Starson v Swayze*, *supra* note 10.

[106] The CCB determined that Starson was incompetent to consent to the treatment. See *Starson v Swayze* (1999), 22 Admin LR (3d) 211. This decision was appealed to the Ontario Superior Court of Justice, which overturned the CCB's decision. The Ontario Court of Appeal unanimously agreed with the Super Court. See *Starson v Swayze* (2001), 33 Admin LR (3d) 315.

[107] *Starson, supra* note 10 at paras 61-64.

[108] *Ibid* at paras 7-10.

Crucially, both the majority and minority opinions agreed on the matter of law - the *HCCA*'s definition of competence was solely concerned with the capacity of the individual and did not permit any consideration of whether or not treatment would be beneficial for the person.[109] The disagreement in the Supreme Court arose as to the CCB's application of the competency criteria in the *HCCA* to Starson's case, and specifically, what it takes to satisfy the "understand and appreciate" standard of competence which is codified in section 4(1) of the *HCCA*. Since it is essentially this same criteria which applies to determining competence across all Canadian jurisdictions due to substantially equivalent legislation definition of the concept, the consequences of the Supreme Court's decision are far-reaching. The contentious point in the case concerned the evidence pertaining to Starson's substantial denial that he suffered from any mental illness and how these facts applied to the competency analysis prescribed in the *HCCA*.[110]

The Court was faced with determining how much insight or lack thereof a person must experience in regards to their mental illness before they can be considered incompetent to consent to treatment for it. The Court endorsed and explicated the competency assessment criteria of the *HCCA*, that being the "understand and appreciate" standard, noting its wide acceptance in the clinical environment.[111] The minority opinion was that Starson could neither appreciate the nature of his illness nor acknowledge the benefits or risks of the proposed treatment, since he saw it all as unnecessary from the outset. That is, although he was capable of understanding what bi-polar disorder was, he evidently could not appreciate the full extent of how it was actually impacting his thought process.[112] The majority disagreed and found that Starson's denial of mental disorder did

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[109] *Ibid* at para 16-19.

[110] *Supra* note 10 at paras 30-31, 93-95. Starson acknowledged that his brain did not function normally but he did not conceive of this as a mental illness which required treatment.

[111] *Ibid* at paras 17-18. While this endorsement was made by Chief Justice McLachlin for the minority, there is no indication that the majority opinion did not essentially agree with this characterization of the standard. The Chief Justice enumerated the three commonly accepted clinical indicators of competence as being: "whether the person is able to acknowledge the fact that the condition for which treatment is recommended may affect him or her; whether the person is able to assess how the proposed treatment and alternatives, including no treatment, could affect his or her life or quality of life; [whether] the person's choice is not substantially based on a delusional belief".

[112] *Ibid* at paras 37-49. Chief Justice McLachlin cited the distinction made by Arbour, JA in a previous case, noting that there is are distinct requirements in a competency assessment that the person both understand the details and information relating to the mental illness which they have been diagnosed with and that they appreciate how it applies to their own circumstances. Crucially, the second element of appreciation of the impact of the mental illness can be disrupted by the mental illness itself, especially in the case of illnesses which cause delusions, even though the person may still be able to understand in more general terms the details of the mental illness generally. See *Khan v St Thomas Psychiatric Hospital* (1992), 7 OR (3d) 303 (CA) at p 314. Though the court did not draw such an analogy, the problem here could perhaps be analogized to the case of an alcoholic who understands what alcoholism is yet does not appreciate or recognize the symptoms of it in themselves, thus enabling them to deny they have the illness.

not in itself negate the "appreciation" requirement of the statutory competency test and that it was sufficient that he acknowledged that his brain "functioned differently" than most other people.[113] In the majority opinion, Starson simply had different priorities than most others, preferring to be an abnormal thinker, even one that is incarcerated in an institution, rather than a medicated and resultantly stunted thinker, based on his prior experience with medication. The majority of the Court took the view that the CCB, in assessing Starson's competence, was essentially imposing a "best interests" standard on him, thus ignoring his own treatment decisions and life priorities in favour of compelling treatment which *it* believed would be most beneficial to him.[114]

As a result of the decision, Starson was not treated and continued to remain committed to the institution for several years. His mental health status fluctuated and he eventually regained some liberties, however he later deteriorated, assessed as incompetent, and treated based on the consent of his substitute decision-maker.

In effect, the Supreme Court's internal disagreement spoke to the standard of capacity or competency which a person must have in order to satisfy the competency criteria of their applicable mental health legislation. The majority opinion arguably had the effect of lowering the factual standard of mental competence, thereby making it easier for someone to be assessed as competent to refuse treatment, as it was deemed sufficient for the "understand and appreciate" standard that the person have only enough insight so as to recognize that their thought processes are abnormal. The minority opinion would have held a greater level of insight as a requirement but that opinion did not carry the day. As Monique Dull has pointed out, patients, mental health practitioners, and mental health advocates are also divided on this outcome. Some hail the lowered standard of competence as a reaffirmation of mental health patient's rights and autonomy, while others see it as an impediment to treatment and a barrier which will result in, paradoxically, more mental health related detentions in hospital as people with mental disorders will be more likely to be untreated and therefore deteriorate.[115]

It is important to note that the decision in *Starson* has not been evenly applied, with many lower courts openly declining to follow the case or endeavouring to distinguish the facts from the case so as to avoid similar results—either an involuntary admission coupled with an inability to

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[113] *Ibid* at paras 93-95.

[114] *Ibid* at paras 109-113.

[115] See Monique W Dull, "Starson v. Swayze, 2003-2008: Appreciating the Judicial Consequences" (2009) 17 Health L J 51.

treat the patient, or the inability to admit or treat the patient because they are competent yet evidently posing a danger to themselves or others.[116] This may evince a lack confidence in the practical applicability of the lower threshold for competency established by the majority in *Starson*, favouring instead the more treatment-oriented higher standard of capacity endorsed by Chief Justice McLachlin's minority opinion.[117] Many commentators agree that the most crucial element of the capacity assessment process is in the "appreciation" criteria, as this involves not only the understanding of relevant information about one's mental disorder, but a deeper ability to cognitively and affectively identify how it is modifying their thoughts and behaviours. One's mental disorder may not impair the person's ability to understand matters of fact, but might instead distort their affective response or priorities such that they do not apply their understandings in what would be considered an appropriate way.[118] Of course, when taking stock of the impact which one's mental illness might have on their ability to appreciate their condition, one must be aware of the specter of the paternalistic "best interests" test. Mere disagreement with a diagnosis or a preference against treatment should not, in and of itself, evince a failure to appreciate one's circumstances.[119]

This legislative approach to involuntary admission and treatment for mental illness in particular, where the decisive criteria for the former is danger and the in the latter case is competence and consent, has been considered and affirmed by the courts in Ontario, perhaps most emphatically in *Fleming v Reid*.[120] One of the contentious issues in this case concerned whether or not a patient's competently made past refusal of treatment could be overridden by the healthcare team or substitute decision-maker once the patient became incompetent. The plaintiffs in this case, both diagnosed with schizophrenia and both admitted as involuntary patients, initially refused treatment with neuroleptic drugs on the basis of their past experiences with the drugs and their belief in their inefficacy. At the time both were assessed as being competent to consent to this treatment and so their refusal was to be honored. Eventually their condition deteriorated and they

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[116] *Ibid*.
[117] *Ibid*.
[118] For instance, a person might understand that they have bi-polar disorder yet refuse treatment for it on the basis that they don't "feel" sick or don't see their manic behaviour as problematic when they are in the midst of a manic episode, despite the fact that when medicated, they always regret the behaviour. See eg Ivana S Markova, *Insight in psychiatry* (Cambridge: Cambridge University Press, 2005); BF Hoffman, *The Law of Consent to Treatment in Ontario*, 2d ed (Toronto: Butterworths, 1997).
[119] See Ruth Macklin, "Some problems in gaining informed consent from psychiatric patients" (1982) 31 Emory L J 345 at 364.
[120] *Fleming v Reid, supra* note 32.

became incompetent to consent but still purported to refuse the treatment. Their attending physician applied to the Review Board, as permitted by certain provisions in the *Mental Health Act* at the time, for an order allowing treatment of the patients, now incompetent, notwithstanding their prior competently made refusals.[121] The Review Board granted this order and the plaintiff patients appealed, eventually up to the Ontario Court of Appeal, arguing that the provisions empowering the Review Board to nullify their prior competent refusal of consent essentially amounted to treating a competent patient against their will, and that this was contrary to section 7 of the *Charter*.

The Court agreed that the impugned provisions of the statute violated the plaintiffs' right to security of the person under section 7 of the *Charter*.[122] In making this determination the Court emphasized the traditional common law principle that all adult patients, regardless of the nature of their illness, to determine their course of treatment, and that this right does not disappear upon admission to a psychiatric facility.[123] At the more general level, the Court added that "[t]he common law right to bodily integrity and personal autonomy is so entrenched in the traditions of our law as to be ranked as fundamental and deserving of the highest order of protection."[124] Numerous other cases have also upheld personal autonomy in the medical treatment context—the right to be free from unwanted treatment—to be of paramount importance, notwithstanding that such refusals may not be in the patient's medically determined best interests.[125] *Starson* emphatically preserves this understanding and valuation of individual autonomy in the mental health treatment in particular.[126] Ontario's current *Mental Health Act* and the *HCCA* have been designed in such a way as to reinforce the principles established in *Fleming*, placing the patient's autonomy, as instantiated through competent consent or refusal of treatment, as the deciding factor in treating mental illness, as opposed to considerations of the patient's best interests.[127]

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[121] The provisions empowering the Review Board are not in the current *Mental Health Act*, existing only in its previous iteration. See *Mental Health Act*, RSO 1980, c 262, ss 35(2)(b)(ii), 35(a).

[122] *Ibid* at paras 40, 51-61.

[123] *Ibid* at para 33.

[124] *Ibid* at para 39.

[125] See eg *AC v Manitoba (Director of Child and Family Services)*, *supra* note 32; *Malette v Shulman* (1990), *supra* note 63; *Ciarlariello v Schacter*, *supra* note 66.

[126] Carver, *supra* note 15 at 311.

[127] *Ibid* at 310.

Ontario's Approach Summarized

In brief, Ontario's legislation provides that involuntary psychiatric admission in relation to a mental disorder can be authorized when the patient represents a danger to themselves or others, (the harm criteria) whether it is imminent or indirect, based on assessment by the examining physician and their determination of whether or not there will be inevitable impairment in the future if the person is not admitted. Involuntary treatment on the other hand is not governed by the harm criteria, but by competence. Since the law strictly requires informed consent on the part of patients prior to receiving treatment, this means that incompetent patients will be treated on the basis of direction received from substituted decision makers, and competent patients may not be treated against their will at all. While the combined effect of these approaches to involuntary admission and treatment arguably correspond with Canadian *Charter* values, it can also give rise to the problem at the center of this thesis: the involuntary detainment and admission of persons with a mental disorder, on the basis that they meet the dangerousness standard for involuntary admission, yet if they are assessed as competent to consent to or refuse treatment, they can refuse the treatment and potentially remained confined for longer periods, untreated, as in the exemplar case of Scott Starson. In short, this freedom from treatment which the law grants them on the basis of their competence may simply translate to a loss of other freedoms and a potential decline in mental health status as they are left to "rot with their rights on".[128]

Quebec

Due to the applicability of civil law in Quebec, compulsory treatment is governed somewhat indirectly by various broad provisions within the *Civil Code of Québec*,[129] however it is also supplemented with specific provisions from dedicated mental health legislation.[130] The fundamental starting point for medical law under the *CCQ* is the guarantee of integrity of the person, which holds that "[e]very person is inviolable and is entitled to the integrity of his person.

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[128] See Thomas Guthiel, *In Search of True Freedom: Drug Refusal, Involuntary Medication, and "Rotting With Your Rights On"* (1980) 137 Am J Psychiatry 327. See also R Solomon, J Gray, R O'Reilly et al, "Treatment Delayed and Liberty Denied" (2009) 87(3) The Canadian Bar Review 679. Commentators such as Solomon et al and Guthiel argue that such patients are free from paternalistic intervention only to be shackled by their untreated symptoms of their illness, recommending different approaches to involuntary treatment which would not permit lengthy hospital stays without receiving treatment. This position is explored later in this work and forms the basis of my thesis, as will be discussed.

[129] *Civil Code of Québec*, SQ 1991, c 64 [CCQ].

[130] *An Act respecting the Protection of Persons Whose Mental State Presents Danger to Themselves or to Others*, RSQ, c P-38.001 [Quebec Mental Health Act].

Except in cases provided for by law, no one may interfere with his person without his free and enlightened consent."[131] The *CCQ* also requires that competent patients provide consent before they are given any medical treatment, subject only to the exceptional case of treatment in emergency situations when consent cannot be obtained.[132] In addition, the *Québec Charter of Human Rights and Freedoms* makes it clear that one of the duties of physicians is to obtain informed consent from patients before treating them.[133]

Involuntary assessment, confinement, and admission to a psychiatric facility is governed under the CCQ. Temporary confinement may be done for the purposes of examination and assessment, or in cases where the person represents an imminent danger to themselves or others. Preventative confinement for psychiatric examination is also authorized under *An Act respecting the Protection of Persons Whose Mental State Presents Danger to Themselves or to Others.*[134] Extended confinement can only be instituted by a court order and only when the court has serious reason to believe that the patient is dangerous and confinement is necessary to mitigate it.[135]

The right for patients to refuse treatment is strong in Quebec. Notably, the CCQ provides that any patient, competent or not, may "categorically refuse" treatment, and if this occurs a court order must be obtained to treat them, except in the case of emergencies or for hygiene issues.[136] Based on the fundamental provisions of the CCQ concerning integrity and requiring consent for treatment, with the only recourse being to obtain a court order to compel treatment, competent patients can expect to have their right to refuse treatment given far more weight in Quebec than in other Canadian jurisdictions which permit internal review boards to override objections to treatment.[137]

As is clear from the legislation, dangerousness is essentially the sole criteria for involuntary admission to a psychiatric facility, while competence is the deciding factor in determining whether or not the person can be given psychiatric treatment, since their consent is an absolute requirement if they are competent to give it. Neither piece of legislation, however, defines competence or capacity, leaving it as a strictly medical determination and a question of fact for the court when it

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[131] *Ibid*, art 10.

[132] *Ibid*, arts 11, 13.

[133] *CCQ* arts 10, 11; *Québec Charter of Human Rights and Freedoms*, RSQ c C-12, s 1.

[134] *Quebec Mental Health Act*, art 6.

[135] *CCQ*, arts 26-31.

[136] *Ibid*, art 16.

[137] Consider, for example, Alberta or Manitoba, where the Mental Health Review Board can authorize treatment of competent patients when it is in their best interests.

is asked to consider ordering treatment for the patient against their objections. Keeping the criteria of dangerousness and capacity separate, the Quebec Court of Appeal has clarified that dangerousness is not a valid consideration in the evaluation of a person's mental capacity, however there is little guidance beyond this distinction, leaving the determination of capacity to the examining medical professional.[138]

Manitoba

Similar to the statutes of Ontario and Quebec, Manitoba's *Mental Health Act* also maintains the approach of distinguishing between involuntary admission and involuntary treatment.[139] The result is that a person may be involuntarily admitted based on the harm criteria, but the regime concerning their treatment is based on competence, wherein a competent patient must provide consent for all treatment except for emergency treatment or treatment to prevent imminent harm. Involuntary examination is predicated on the suspected presence of a mental disorder as well as the belief that the person is likely to cause substantial harm to themselves or others or is likely to suffer "substantial mental or physical deterioration" without treatment.[140] Involuntary treatment is dealt with under an entirely separate part of the Act, and it explicitly notes that the patient has the right to refuse treatment, except in accordance with the provisions of the Act.[141] The patient's right to consent or refuse consent to treatment is premised on their competence.[142]

When the patient is incompetent the Act provides that various substitute decision makers can make treatment decisions on their behalf.[143] These decisions must be made either on the basis of the patient's prior expressed wishes when they were competent or if such is not known by the substitute decision maker, based on what is in the best interests of the patient. The best interests standard shall take precedence over the patient's prior expressed wishes in the decision making process when the prior expressed wishes would "endanger he physical or mental health or the

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[138] *Institut Philippe Pinel de Montréal v Gharavy,* [1994] JQ no 837.

[139] *The Mental Health Act,* CCSM c M110.

[140] *Ibid*, s 8.

[141] *Ibid*, s 26.

[142] *Ibid*, s 27(2). This requires consideration of: (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.

[143] *Ibid*, s 28(1)

safety of the patient or another person."[144] Determining the patient's best interests is done by considering whether or not they will likely improve or deteriorate with or without treatment, whether the benefits outweigh the harms, and whether the treatment is the least restrictive and intrusive as is possible.[145]

When the patient is competent to make treatment decisions but is subject to an involuntary admission, the Act is quite clear that they have the right to refuse treatment.[146] While it is arguable that a best interests standard dominates the Manitoban approach to involuntary treatment, this is only so when the patient is incompetent. The two principle exceptions to this are in the case of emergencies where significant harm is inevitable and the person cannot consent, and where the person is competent but treatment is necessary in order to prevent harm to the patient or another person.[147]

Northwest Territories and Nunavut

Mental health treatment in the Northwest Territories and Nunavut is governed by similar mental health legislation, each with identical provisions concerning involuntary treatment for mental illness.[148] Like Ontario, Quebec, and Manitoba, both operate on the admission versus treatment dichotomy, whereby involuntary admissions concerning mental disorders are decided primarily on the basis of dangerousness while involuntary treatment is determined by the competence of the patient.

The harm criteria relating to involuntary admission substantially mirror those found in other jurisdictions, but contain additional provisions, making this harm standard arguably the lowest in Canada, as it includes the criteria of a lack of competence to care for oneself, as well as causing *fear* of harm in others, as opposed to causing actual or threatening imminent harm.[149] That said,

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[144] *Ibid*, s 28(4)(b).
[145] *Ibid*, s 28(5).
[146] *Ibid*, s 29(1).
[147] *Ibid*, ss 29(2), 29(5).
[148] *Mental Health Act*, RSNWT 1988, c M-10 [NWT Mental Health Act]; *Mental Health Act*, RSNWT (Nu) 1988, c M-10 [Nunavut Mental Health Act].
[149] *Ibid,* s 8(1) in both acts. The dangerousness standard permits involuntary admission where the examining medical practitioner reasonably believes that the person:
(i) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself,
(ii) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her, or
(iii) has shown or is showing a lack of competence to care for himself or herself;
…

the Acts give strong protections to competent patients, as it is an explicit requirement with no qualifiers that competent patients must consent to psychiatric treatment.[150] Remarkably, this prohibition on non-consensual treatment even extends to emergency treatment, which is usually an excepted circumstance for treatment without consent in Canadian medical law.[151] Numerous provisions exist governing the obligations and decision making processes for substitute decision makers but these only apply in the case of incompetent patients.[152] Thus, competent patients cannot be treated without their consent.

iii. *The Best Interests Approach: Competent Patients Can Refuse but the Refusal Can Be Overridden in Certain Cases*

Several Canadian jurisdictions have legislated separate provisions and criteria for involuntary admission and involuntary treatment for a mental disorder. Each regime entails a slightly difference process and arrives at different results in respect of the question of whether or not a competent person can be treated for a mental disorder against their objections. Unlike certain previously considered jurisdictions, the following regimes do not implement all-or-nothing approaches, favouring a more nuanced system of admission and treatment. The overall result, however, is that competent patients can refuse psychiatric treatment but there are statutory mechanisms which permit an override of this refusal if treatment is indicated as being in their best interests. As such, this legislative framework represents a "middle ground" between the previously considered approaches to authorizing involuntary psychiatric treatment.

Alberta

While the compulsory committal criteria of the Alberta *Mental Health Act* is primarily based on a harm standard, the compulsory treatment criteria is based on competency criteria.[153] Thus, it is possible for a person to be subject to compulsory admission due to the presence of a

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(c) the person refuses to undergo a psychiatric assessment or is not mentally competent to give a valid consent to undergo a psychiatric assessment

[150] *Ibid*, s 19.1.

[151] See *Malette v Shulman supra* note 63. The Acts stipulate that emergency psychiatric treatment is not permitted without consent from the competent patient. See NWT Mental Health Act and Nunavut Mental Health Act, s 20(1).

[152] NWT Mental Health Act, Nunavut Mental Health Act, s 19.1-19.4.

[153] *Mental Health Act*, RSA 2000, c M-13, ss 26, 27 [Alberta Mental Health Act]. Notably, the word "competence" replaces "capacity" which is most typical in Canadian legislation, though the meaning of both terms in the context of treatment decisions is arguably the same.

mental disorder and the criteria of dangerousness being met yet they may retain the right to refuse treatment because they have not been assessed as incompetent. The Act defines competence as being where "the person is able to understand the subject-matter relating to the decisions and able to appreciate the consequences of making the decisions".[154] If a physician assesses a patient as incompetent they must issue a certificate to the mental health review board, at which point a substitute decision maker shall make treatment decisions on behalf of the patient.[155] The substitute decision maker must make treatment decisions based on the best interests of the patient, which the Act stipulates shall include considerations of potential improvement of the patient if they were to receive treatment, whether or not the patient will deteriorate without treatment, a weighing of the potential risks and benefits of the treatment, and whether or not the treatment is the least restrictive and intrusive as is possible in the circumstances.[156]

Notwithstanding the initial promise of deference to competent patients' treatment preferences, even if a patient is not assessed as being incompetent, the Act still permits an override of their objections to treatment in some circumstances. The refusal of treatment must be respected initially while the patient's attending physician may make an application to the review panel for an order permitting administration of treatment notwithstanding a competent patient's objections if the attending physician believes that it is in the patient's best interests to do so.[157] The panel may grant the order if it is satisfied that the "best interests" criteria, mirroring that described for substitute decision makers, is satisfied in the circumstances.[158] In short, once a person is subject to compulsory committal or a community treatment order, their treatment decisions may be carried out on a best interest basis, regardless of whether or not they are competent to consent to or refuse the treatment. Given that the treatment in question would likely not be proposed for the patient by their physician if it were not in their best interests, this means that the even competent patients will have a limited ability to object to treatment.[159]

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[154] *Ibid*, s 26.

[155] The Act provides a hierarchical list of substitute decision makers, including the patient's agents, guardians, or relatives. See section 28.

[156] *Ibid*, s 28(3),(4).

[157] *Ibid*, s 29. As per section 34 of the Alberta Mental Health Act, the review panel consists of a physician, psychiatrist, a member of the public, and a chair.

[158] *Ibid*, s 29.

[159] In theory, the requirement of the health care professionals to seek approval from the review panel before implementing treatment which has been objected to amounts only to an extra procedural step, however even this amount of oversight is arguably useful as it forces mental health professionals to justify their proposed treatment to a partially external body.

Prince Edward Island

Prince Edward Island's *Mental Health Act* distinguishes between involuntary admission and involuntary treatment.[160] Again, the harm criteria is the primary consideration in determining whether a person ought to be involuntarily admitted to a psychiatric facility.[161] Likewise, treating the patient requires their consent if they the requisite capacity to offer it, which is determined by considering whether or not they can understand the nature of the treatment, its risks and benefits, and the consequences of accepting or refusing it.[162] Substitute decision makers can offer consent on behalf of incompetent patients, but must act in the best interests of the patient.[163] Competent patients do not have an absolute right to refuse treatment, however, as they can be treated without their consent in emergency situations to prevent imminent and serious damage to themselves, as well as when it is necessary to "keep the patient under control and to prevent harm to the patient or to another person".[164] Ultimately, the competent patient's right to consent is subject to the "best interests" standard.[165] Therefore, while Prince Edward Island's regime initially purports to reinforce the right of competent patients to refuse treatment by explicitly stating such as well as distinguishing admission and treatment criteria, the possibility for recourse to the Review Board for a best interest assessment can, in theory, nullify this right to refuse.

New Brunswick

New Brunswick's *Mental Health Act* contains very similar provisions to those in Prince Edward Island.[166] Competent objections to treatment can be overridden by the appointed mental health tribunal, which is analogous to the Review Board in Prince Edward Island. The involuntary admission criteria set the harm threshold as being danger caused by a mental disorder "of a nature

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[160] *Mental Health Act*, RSPEI 1988, c M-6.1.
[161] *Ibid*, s 13.
[162] *Ibid*, s 23(3).
[163] *Ibid*, s 23(9).
[164] *Ibid*, ss 23(11), (12).
[165] *Ibid*, s 24(2). Specifically, these considerations include whether or not:
(a) the mental condition of the patient will be or is likely to be substantially improved by the specified psychiatric treatment;
(b) the mental condition of the patient will not improve or is not likely to improve without the specified psychiatric treatment;
(c) the anticipated benefit from the specified psychiatric treatment and other related medical treatment outweighs the risk of harm to the patient; and
(d) the specified psychiatric treatment and other related medical treatment are the least restrictive and least intrusive treatments that meet the requirements of clauses (a), (b), and (c).
[166] *Mental Health Act*, RSNB 1973, c M-10.

or degree so as to require hospitalization in the interests of the person's own safety or the safety of others".[167] After this initial stage, if the patient objects to further assessment, admission, or treatment, the attending physician can apply to the mental health tribunal for an order permitting involuntary admission. Such an order can be granted if the tribunal is satisfied that the dangerousness criteria is met. The competence of the person must be assessed as soon as possible, though competence is not defined in the statute, leaving it as purely a psychiatric determination of fact.

Whether or not the patient is competent may be irrelevant where treatment is concerned, since regardless of whether or not the patient is competent, the physician may apply for an order from the tribunal permitting "routine clinical medical treatment" without the consent of the person.[168] The statute outlines the criteria for obtaining this order, including, among other things, that "without the treatment, the person would continue to be detained as an involuntary patient with no reasonable prospect of discharge."[169] The statutory definition of best interest is in keeping with other definitions which have been discussed.[170] Notably, the Act indicates that psychiatric treatment requires consent of competent patients, except in accordance with the "best limited right to refuse psychiatric treatment in any case. Despite the ready recourse to overriding competent refusals of treatment, it is interesting to note the purpose for doing so, as exemplified in the previous provisions—that it is in the patient's best interests *and* that without such treatment the patient would remain admitted to the facility indefinitely. These provisions militate against the practice of warehousing patients with mental illnesses while refraining from treating them, but arguably at a cost of their immediate medical autonomy.

Yukon Territory

Lastly, in the Yukon Territory, the *Mental Health* Act distinguishes between involuntary admission and involuntary treatment of competent patients, but eventually permits an override of competent refusals of treatment based on the principle of acting in the patient's best interests.[171] As is typical, involuntary admission criteria focus on the presence of danger arising out of the patient's mental illness. For an involuntary admission certificate to be issued by the examining

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[167] *Ibid*, s 7.1(1).
[168] *Ibid*, s 8.11(1)-(3).
[169] *Ibid*, s 8.11(3).
[170] *Ibid*, s 8.11(4).
[171] *Mental Health Act*, RSY 2002, c 150.

physician, they must find that the patient is suffering from a mental disorder and that, unless hospitalized, they are likely to cause serious bodily harm to themselves or another or they are likely to suffer physical or mental impairment.[172] The Act specifies that competent patients must offer consent to treatment, and competence is determined by reference to the typical competence criteria—whether or not the patient understands the nature of the proposed treatment and the consequences, benefits, and risks of accepting or rejecting it.[173] However, the Act subsequently permits the treating physician to apply to the Mental Health Review Board for an order permitting treatment of a competent patient who is refusing treatment. The criteria upon which the Board must base its decision is the best interests standard, albeit that the statute does not refer to it as such. The wording of the criteria is substantially similar to those provisions discussed in the previous jurisdictions, including, for instance, consideration of whether or not the treatment benefits would outweigh the risks, the likelihood of substantial improvement with the treatment, and whether or not it is the least intrusive treatment possible.[174]

To summarize, Alberta, Prince Edward Island, New Brunswick, and Yukon Territory distinguish criteria which enables involuntary admission and involuntary treatment, where admission is based on the standard of dangerousness and the ability to treat a patient without their consent depends on whether or not they are competent to offer it. However, unlike other Canadian jurisdictions which grant absolute protections to a patient's right to refuse treatment if they are competent, these jurisdictions attenuate this right by permitting recourse to a the local mental health review board which may authorize an override of the patient's refusal if it is in their best interests to receive treatment.

D. Summary of Canadian Legislative Regulation of Involuntary Psychiatric Treatment

An analysis of provincial statutes pertaining to involuntary psychiatric treatment reveals four divergent approaches which center around the competency of the patient in question. The pre-eminence of mental competence as the concept, upon which legislation balances personal autonomy against the paternalistic mental health institutions, arises from the *Charter* and the

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[172] *Ibid*, s 13.
[173] *Ibid*, ss 21(1), 19.
[174] *Ibid*, s 23(3), (4).

common law, as instanced in the seminal cases of *Ciarlariello v Schacter*, *Malette v Shulman*, and *Fleming v Reid*, and *Starson v Swayze.* Since it would run afoul of the section 7 of the *Charter* and the noted common law principles to treat competent patients without their consent, legislation must work around this basic starting point.

One approach—the paternalistic approach, taken by British Columbia, essentially ignores this principle of balancing interests as well as the psychiatric reality of many people with mental disorders, presuming involuntary patients to have impliedly consented. Arguably, this approach is vulnerable to constitutional challenge. A second approach, that taken by Saskatchewan, Newfoundland, and Nova Scotia, collapses involuntary admission and treatment criteria together to the extent that a patient must be incompetent to be admitted or treated. In both cases, the problem of "warehousing" patients is avoided, as all patients who are admitted on an involuntary basis can potentially be treated on an involuntary basis as well; the difference is how British Columbia achieves this on a purely paternalistic basis, while the other jurisdictions err on the side of declining to admit patients with a mental illness who are competent, even when they are assessed as potentially dangerous.

The third approach prioritizes the autonomy rights of the patient and is followed by Ontario, Quebec, Manitoba, the Northwest Territories, and Nunavut. Legislation in these jurisdictions clearly indicates that competent patients cannot be subject to involuntary treatment and provides no exceptions to this rule, save for emergency situations. In short, competent patients have the right to refuse psychiatric treatment, and the only way to impose involuntary treatment is to establish that the patient is in fact incompetent.

The fourth approach, followed in Alberta, Prince Edward Island, New Brunswick, and the Yukon Territory, represents middle ground approach in balancing the principles of medical paternalism and patient autonomy. Under this approach, competent patients have a right to refuse psychiatric treatment but the legislation provides for some administrative or quasi-judicial method of overriding this refusal on the basis that treatment is in the patient's best interests. Arguably, however, an assessment of their best interests will reduce to an analysis of their medical best interests, resulting in a preference for treatment over a respect for refusals.

Applying these varied approaches to the problem of the chronic cycler suffering from schizophrenia will obviously yield different results, and the manner in which the patient is treated will vary based on where they reside. One can easily imagine that Scott Starson's experience with the mental health care system would have been different had he been resident of, for instance, British Columbia (and therefore presumptively had no right to refuse treatment), or Alberta (where the best interests assessment conducted on him would have been sufficient to authorize treatment).

Each of these legal frameworks to dealing with the problem of the chronic cycler strike the balance between patient autonomy and paternalism in a different way, each of which is open to its own critique, however before discussing these critiques it is necessary to examine the applicability of advance directive legislation to the problem of the chronic cycler, as it could, in theory, permit patients to mandate their own future involuntary treatment.

E. Critiques of Canada's Mental Health Legislation

In a recent report the Standing Senate Committee on Legal and Constitutional Affairs has commented on the failure of the mental health care system to adequately respond to the needs of patients.[175] Noting the complications arising from an inconsistent approach between the provinces, the report indicates that "[m]ore work is needed to determine the cause of these significant failures, particularly the right of seriously mentally disordered individuals to refuse treatment and the interpretation given by the courts to that right. This is an approach that may have serious adverse consequences, both for the mentally disordered individual and for society at large"[176]

As discussed, one jurisdiction essentially combines the processes and criteria for involuntary admission and involuntary treatment, arguably achieving efficiency and avoiding the "warehousing" of patients with mental disorder; however, this comes at a cost of potentially overruling competent patients' medical autonomy on the basis that they are considered dangerous.[177] Other jurisdictions opt for a "hands off" approach to both involuntary admission and treatment for those who are assessed as competent, respecting their rights but arguably placing their mental and physical health in jeopardy.[178] Another approach is to involuntarily admit patients on the basis that such is necessary for their own protection, but decline to treat them if they are

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[175] Canada, Senate, The Standing Senate Committee on Legal and Constitutional Affairs, *Fourth Report of the Standing Senate Committee on Legal and Constitutional Affairs (Bill C-14)* (27 March 2014) (Chair: Bob Runciman). The committee reported on *An Act to amend the Criminal Code and the National Defence Act (mental disorder)* RSC 2014 c C-6. Although this report relates primarily to NCR and related dangerous offender provisions, the critique of the failure in the medical side of the mental health system remains relevant even in cases where mental health patients do not represent a danger to society.

[176] *Ibid* at para 4.

[177] British Columbia is the only jurisdiction to follow this strict approach.

[178] Saskatchewan, Nova Scotia, and Newfoundland follow this approach.

competent, thus maximally respecting their medical autonomy but resultantly "warehousing" them without treatment, perhaps more greatly impacting their long term liberty and health.[179] Some jurisdictions purport to follow this approach but will ultimately overrule competent objections based on a "best interests" standard, which may achieve better health outcomes for the patient but involves a compromise of their medical autonomy.[180] Each of these approaches can be praised or faulted, depending on whether one prioritizes a paternalistic, best-interests pro-treatment approach, or a rights-based, patient autonomy approach, and indeed, this division is exemplified through the divergent critiques in the literature.

1. The Patient Autonomy Position: Canadian Health Law is Generally Too Paternalistic

H Archibald Kaiser argues that Canadian mental health law remains "predominately coercive, reactive and crisis-oriented", still failing to embrace the often lauded principles of the least restrictive and intrusive provision of care.[181] In particular, Kaiser is critical of the lack of legislation and resources directed towards promoting equality and the positive rights of mental health consumers which would be gained by ensuring the availability of appropriate, non-coercive mental health care to those who need it.[182] Also problematic is the general lack of broad purposive guiding statements and preambles in mental health legislation, the absence of which signals a lack of understanding of the legal and non-legal issues which mental health consumers must face, and which fails to provide guidance to decision-makers in adjudications concerning mental health consumers, thus permitting a backwards step towards inappropriate levels of paternalism.[183] Indeed this critique seems to bear out as legislation, reinforced by common law and *Charter* principles, tends to focus on only the negative rights of patients in a health care setting.

Kaiser has also argued that in spite of the deinstitutionalization movement of the 1960's through the 1980's, as well as the development and implementation of the *Charter*, mental health law still remains substantially paternalistic and lacking in social support mechanisms for

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[179] Ontario, Quebec, and Manitoba follow this approach.
[180] Alberta, Prince Edward Island, New Brunswick, and the Yukon Territory follow this approach.
[181] *Supra* note 7 at 185.
[182] *Ibid* at 197.
[183] *Ibid* at 190.

facilitating the positive entitlement and actual enjoyment of the rights which all Canadians are guaranteed.[184] She argues that

> [t]he typical mental health statute evinces almost complete silence on human rights protections, equality rights and discrimination, health promotion, crisis prevention and positive rights to supports and services based upon a broad conception of health determinants. There is a concomitant minimization of advocacy supports, key procedural protections, judicial or tribunal scrutiny and the least restrictive, least intrusive and least onerous principle.[185]

It has also been pointed out that Canadian legislation tends not to emphasize the principle of the least restrictive, least onerous, and least intrusive principle when it comes to treating mental health issues.[186] Three jurisdictions do not mention the principle in their mental health legislation,[187] four make reference to the principle in relation to determinations of the patient's best interests and the appropriateness of issuing a community treatment order,[188] while six make some reference to it in both their preambles as well as again in the body of the legislation,[189] but

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[184] H Archibald Kaiser, "Canadian Mental Health Law: The Slow Process of Redirecting the Ship of State" (2009) 17 Health L J 139.

[185] *Ibid* at 141.

[186] *Ibid* at 143.

[187] British Columbia's mental health act makes no reference to a standard of minimal intrusiveness. See *Mental Health Act*, RSBC 1996, c 288. Saskatchewan makes no such reference either. See *Mental Health Services Act*, *supra* note 60. Quebec's pertinent legislation is also silent on the principle. See *An Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others*, RSQ, c P-38.001 *supra* note 130; *Civil Code of Quebec supra* note 129 arts 26-31.

[188] Ontario's *Mental Health Act* contains no broad purposive statement about minimal restrictiveness, albeit that it indicates that the purpose of community treatment orders includes the intention to provide patients with less restrictive care options than would be received if detained in hospital. See *Mental Health Act*, RSO 1990, c M.7. 33.1(3). Ontario's *Healthcare Consent Act* also contains reference to the principle insofar as court ordered treatment pending an appeal must ensure that the treatment will either substantially improve (or prevent substantial deterioration of) the patient's condition and it is the least restrictive and intrusive treatment possible. It is also noted to be a factor in the best interests assessment of the patient concerning substitute decision making that the treatment in question, as well as a consideration in determining the optimal venue of treatment for the patient. See *Health Care Consent Act, 1996* SO 1996 c 2 ss 19(2)(c), 21(2), 34(5). Similar provisions as to the appropriateness of CTOs, the determination of a patient's best interests, and considerations of patient objections to treatment exist in Alberta's *Mental Health Act*. See *Mental Health Act*, RSA 2000, c M-13, ss 9.1(1), 28(4), 29(3). Manitoba has similar provisions as well, again in respect of the patient's best interests, objections to treatment, and use of CTOs (leave certificate). See *Mental Health Act*, CCSM c M110, ss 28(5), 30(2), 46(1), 95.

Prince Edward Island's *Mental Health Act* requires that the proposed treatment be the least restrictive and intrusive possible, and that the principle be given weight when considering the appropriateness of a CTO. See *Mental Health Act*, RSPEI 1988, c M-6.1, ss 24(2), 25(1).

[189] Newfoundland's *Mental Health Care and Treatment Act* state's that, among other things, its purpose is to provide care in the least restrictive and intrusive manner possible, and that these considerations also factor into determining the best interests of the patient. See *Mental Health Care and Treatment Act*, SNL 2006 c. M-9.1, ss. 3(1)(c), 35(2). Nova Scotia's legislation requires that mental health treatment be "offered in the least-restrictive manner and

not forcefully, according to Kaiser.[190] The promise of the *Charter* has not been realized in the context of the rights and flourishing of people with mental illness for a number of reasons, but one significant roadblock, Kaiser argues, is our continued reliance on the medical model of mental health and disability generally, as opposed to the social model of disability, which would locate the problem more in the lack of social support structures and inclusion.[191] The focus on the medical also reinforces the paternalistic approach to treating those who are mentally ill, contrary to the ideals espoused in the *Convention on the Rights of Persons with Disabilities,* (CRPD), which focuses on empowering individuals with disabilities to make their own choices.[192] For instance, the CRPD includes both positive rights to support in decision-making and treatment, as well as protection from unwanted treatment, both of which are vulnerable to certain mental health legislative provisions.[193]

In short, the argument is that the majority of Canadian health law falls short of respecting the autonomy-related rights guaranteed by the *Charter* because it is too paternalistic and inattentive to the actual needs of the patients to which is applies.

2. *The Paternalistic Position: Canadian Mental Health Law Should Prefer Patient Medical Welfare to Autonomy Rights*

In contrast to the critique of Canadian mental health legislation by Kaiser, others argue that legislation is too often ineffective and wrongly sacrifices patients' medical well-being in the name of rights which may be illusory.

As already noted, Monique Dull has pointed out Canadian courts' reluctance to follow the majority ruling of *Starson*, which had arguably lowered the standard necessary for a person with

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environment with the goal of having the person continue to live in the community or return to the person's home surroundings at the earliest possible time". See *Involuntary Psychiatric Treatment Act*, SNS 2005, c. 42, s 2(c), 40(d). New Brunswick's legislation establishes the principle in its purpose, it's criteria for granting CTOs, and the assessment of the patient's best interests. See *Mental Health Act*, RSNB 1973, c M-10, ss 1.1(c), 8(1), 8.6(9). Yukon's legislation states the principle in its preamble as well as invokes it as a consideration for granting a temporary release, but is not mentioned as a consideration for determining the patient's best interests. See *Mental Health Act*, RSY 2002, c 150, s 26(1). Legislation in the Northwest Territories (and Nunavut) legislation contains a purposive statement as to treatment being the least restrictive and intrusive as is possible in the preamble but does not mention the principle again elsewhere. See *Mental Health Act*, RSNWT 1988, c M-10 Nunavut's mental health legislation is duplicated from the Northwest Territories. See of the *Nunavut Act*, SC 1993, c 28, s 29.

[190] *Ibid* at 142.

[191] *Ibid* at 145, 147.

[192] *Supra* note 14.

[193] These rights arise in a number of provisions, including, for instance, the freedom to make one's own choices generally (s 3(a), the requirement to provide measures for actual facilitation of a disabled person's legal capacity, (s 12(3)), and the right to live in a community and make choices on an equal basis with non-disabled persons (s 19).

a mental disorder to be found competent to refuse treatment. This low standard, combined with Ontario's approach to involuntary commitment and treatment, results in a warehousing of patients, admitted because they are dangerous but untreated because they are deemed competent enough to refuse it.

Similarly, Solomon et al have argued that Ontario's approach—warehousing people who are dangerous but competent, has the effect of sacrificing liberty for a false notion of autonomy.[194] Taking Starson's case as an exemplar, they point out that Starson's victory was hollow, since his achievement of the status of competent merely meant that rather than be treated, his mental health would continue to deteriorate and he would be detained for nearly seven years in various institutions before finally being treated. A number of other lower court cases are surveyed by the authors, each with similar unfortunate results.[195] Essentially, the argument that these authors make is that in these cases, the individuals were detained involuntarily for years, thus "they experienced a prolonged and eventually futile loss of liberty while … completely or mostly untreated".[196] The authors are critical of mental health regimes, such as that in Ontario, which permit extended periods of non-treatment, detention, and deterioration, pending appeals of capacity assessments. They argue that, in addition to expediting the appeal process, the best approach to treatment is exemplified in jurisdictions which avoid the deteriorating effects of warehousing by either implementing a best interests override of treatment refusals (what they refer to as balancing liberty and autonomy with well-being), or amalgamating the requirements of involuntary admission and treatment, admitting only incompetent patients who can be treated.[197] Acknowledging this

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[194] See Robert Solomon et al., *supra* note 128.

[195] In one case, the Court found itself in a situation resembling that in *Fleming*, where an incompetent patient's treatment was delayed due to his past refusals of treatment made when he was competent. He was prone to violence and so detained for over five years before the Official Guardian consented to treatment on his behalf. See *Sevels v Cameron*, [1994] OJ No 2123 (Gen Div). In another case, a patient who suffered from delusions and various psychotic symptoms, remained untreated for over 25 years while his case went through multiple assessments and legal determinations. The patient had been convicted of two assaults, and then the assault and sexual assault of his aunt. He successfully invoked the defence of not guilty by reason of insanity (as the defence then was), and was diagnosed with psychotic disorder and several personality disorders, but refused treatment in all but the briefest instances. While he was eventually found to be incompetent, his mother continued to refuse treatment on his behalf as his appointed proxy, on the basis of his past competent refusals. After numerous appeals, and nearly constant detention and deterioration in his condition, the patient remained untreated. See *(Re) Conway*, [2003] ORBD No 309.

[196] *Supra* note 128 at 713.

[197] *Ibid* at 714. These approaches are implemented in various other Canadian jurisdictions. For instance, as discussed above, Alberta, Prince Edward Island, New Brunswick, and the Yukon Territory permit overrides of treatment refusals by competent patients based on an assessment of the patient's best interests. As well, in Saskatchewan, Nova Scotia, and Newfoundland, patients who are involuntarily admitted cannot refuse treatment since they cannot be admitted if they are competent to refuse, thus the warehousing problem is directly pre-empted.

argument, Chief Justice McLachlin of the Supreme Court of Canada, commenting on the challenges to involuntary treatment, aptly summarized the argument that

> 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 ….[198]

The essence of this position is that the mental health and well-being of the patient ought to take precedence over their medical autonomy rights; further, it is arguable that their long term autonomy interests are in fact benefited by a more aggressive treatment approach, since they can be restored to a higher state of independence.

In spite of the divergent approaches which Canadian jurisdictions take in regards to involuntary treatment, it seems likely that the jurisdictions will become more homogenous over time. Indeed, some opine that the mental health law in jurisdictions which permit involuntary treatment of competent patients, either on the basis that their consent is deemed given their involuntary admission, or their objections are overridden by a review board on the basis of a "best interests" assessment, would not survive a *Charter* challenge, in light of cases such as *Starson* and *Fleming*.[199] As such, it is reasonable to anticipate a shift towards the more rights-based deferential approach to involuntary treatment, where competent patient's decisions are given greater protections.

F. Conclusion

The preceding analysis permits an answer to the first part of the primary question of this work: what approach to treatment can and should be implemented for a presently competent psychiatric patient who cycles through periods of non-compliance with their medication to their detriment? As to what approach can be legally enforced, in most Canadian jurisdictions, a

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[198] The Right Honourable Beverley McLachlin, "Medicine and the Law: The Challenge of Mental Illness" (Honourable Mr. Justice Michael O'Byrne/AHRMR Lecture on Law, Medicine and Ethics, delivered at the University of Alberta and University of Calgary, 17 & 18 February 2005), [unpublished]. See also McLachlin, *supra* note 7.

[199] These jurisdictions include British Columbia, Alberta, Prince Edward Island, and the Yukon Territory, as discussed above. See Carver, *supra* note 15; Kaiser, *supra* notes 7 and 184, Simon N Verdun-Jones & Michelle S Lawrence, "The Charter Right to Refuse Psychiatric Treatment: A Comparative Analysis of the Laws of Ontario and British Columbia Concerning the Right of Mental-Health Patients to Refuse Psychiatric Treatment" (2013) 46 UBC L Rev 489.

competent person cannot receive psychiatric treatment without their informed consent, with relatively limited exception.[200] Thus, a psychiatric patient who repeatedly discontinues their medication and resultantly experiences a relapse of symptoms cannot be treated involuntarily until they become incompetent or reside in one of the previously mentioned exceptional jurisdictions; however, given the different jurisdictional frameworks, it will matter greatly where this patient lives. If they live in Ontario, and if they are a danger to themselves or others, they will be treated like Scott Starson, and likely admitted involuntarily but left untreated. If they live in British Columbia, they would likely be treated against their objections. If they lived in Alberta, or another similar jurisdiction, an external review considering their best interests would determine the matter.

In theory, since the all mental health legislation must comport with *Charter* and the common law, and these in turn enshrine the value of autonomy, so-conceived as predominantly a negative right (freedom from interference), what remains to be discussed is whether or not the concept of autonomy referenced herein is conceptually adequate for application in governing involuntary psychiatric treatment. To answer this question, the next step is to discuss the philosophical evolution and critiques of the concept of autonomy.

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[200] The principle exception is British Columbia, where legislation permits deemed consent on the part of involuntarily admitted patients. Alberta, Prince Edward Island, New Brunswick, and the Yukon Territory also permit treatment without consent in some cases where it is in the best interests of the patient to proceed.

CHAPTER 4: The Evolution of the Concept of Autonomy in Bioethics

A. Introduction

The importance of autonomy in medical decision making was expressly acknowledged by the Supreme Court of Canada in *Ciarlariello v Schacter*, in the following oft-quoted passage: "Everyone has the right to decide what is to be done to one's own body. This includes the right to be free from medical treatment to which the individual does not consent. This concept of individual autonomy is fundamental to the common law."[201]

This quotation encapsulates the legal view of autonomy in Canadian medical law – freedom from treatment to which the individual does not consent. This chapter discusses the inadequacy of this conception of autonomy when it is invoked as a consideration in deliberations on involuntary psychiatric treatment. In particular, respecting and enhancing patient autonomy in scenarios involving chronic cyclers of psychiatric medication (as discussed in Chapter 2) becomes a challenge precisely because it appears that their mental illness is influencing their preferences and values.[202] Similarly, for those in scenarios reminiscent of Scott Starson, where the person is evidently dangerous, impaired to a degree by their mental illness, yet still mentally competent, it becomes unclear whether we would be helping or hurting their autonomy by providing treatment which would alleviate the symptoms which are causing their impairment. One thing is certain though – merely referring to autonomy as "freedom from treatment to which the individual does not consent" does not adequately address all of the relevant factors in the case of psychiatric treatment for mental illness.[203]The purpose of this section is to discuss concepts of autonomy in the bioethical discourse that might inform Canada's approach to involuntary psychiatric treatment and permit an understanding of personal autonomy as being more than freedom from non-consented treatment.

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[201] *Ciarlariello, supra* note 66 at para 40.

[202] This exemplar case is one involving a patient suffering from schizophrenia who recurrently destabilizes due to non-compliance with medication.

[203] Clearly, Canadian jurisdictions where the competence of the patient is a moot consideration to involuntary treatment do not face the challenge of determining whether mental competence as a benchmark in involuntary treatment adequately serves the patient's autonomy (British Columbia, Saskatchewan, Nova Scotia, Newfoundland) However, the "all or nothing" approach taken in Saskatchewan, Nova Scotia, and Newfoundland further demonstrates a problem in predicating *both* involuntary admission and treatment on the competence of the patient, as this can result in an inability to admit or treat patients who are dangerous or otherwise deteriorating, until they reach a point of incompetence.

Autonomy as a philosophical construct has undergone substantial reconceptualization which has not been reflected in legislation and jurisprudence which purports to function in service of it. The idea that we should respect patient autonomy is, as O'Nora O'Neil opines, "endlessly repeated but deeply obscure."[204] Frequently in the bioethics literature, commentators invoke the term "autonomy" and apply it indiscriminately, as if it is little more than a synonym for informed consent or personal freedom. I argue that legislation relating to involuntary psychiatric treatment must be attentive to the more nuanced understanding of autonomy which is reflected in this discourse, as well as attuned to the specific challenges of mental illness. To that end, the following sections outline the development of the traditional biomedical concepts of autonomy, as well as discuss modern critiques and formulations of it. In particular, I suggest that feminist critiques which emphasize the analytic utility of the concept of relational autonomy may add a valuable layer of understanding to autonomy *qua* psychiatric treatment. I also discuss commentary specifically concerning autonomy in the mental health context. In doing so I lay the groundwork for understanding the autonomy implicated in involuntary psychiatric treatment as being a function of a coherence of preferences over time, as opposed to merely adopting the principle of informed consent as assessed in the light of (only) contemporaneous mental competency.

B. Autonomy and Consent – Autonomy in Health Care

In the legal sense, autonomy is often equated with informed consent, wherein the former is achieved by legislating and enforcing procedures which guarantee the latter.[205] Some argue that the "patients' rights" approach to medical ethics, instantiated in the focus on the near-exclusive focus on patient autonomy, transforms the physician-patient dynamic from one based on trust and beneficence to one more resembling a consumer-contractual model. By so exalting the concept of autonomy, we forget the ancient purpose of medicine: to provide care and help people.[206] Others

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[204] O O'Neill, "Some limits of informed consent" (2003) 29 J Med Ethics 4 at 5.

[205] In law and ethics, it is generally uncontroversial that the primary elements of informed consent include: the provision of adequate information to the person, ability to understand the information, voluntariness in offering consent, and the expression of such consent. See Sheila A M McLean, *Autonomy, Consent and the Law* (New York: Routledge-Cavendish, 2010) at 40-55. The requirement for obtaining informed consent in medical interventions has traditionally been rooted in the moral duty to respect persons, or personal autonomy. See Benjamin Freedman, "A Moral Theory of Informed Consent" (1975) 5:4 Hastings Center Report 32.

[206] See Alfred Tauber, "Sick Autonomy" (2003) 46:4 Perspectives in Biology and Medicine 484; Daniel Callahan, "Can the Moral Commons Survive Autonomy?" (1996) 26 The Hastings Center Report 41; McLean, *ibid*, at 6.

I take for granted the acceptance of autonomy if a pre-eminent value in Western Society, but acknowledge that some argue that autonomy itself has become an overvalued concept, especially in the realm of medical treatment where many patients readily surrender decision-making power, deferring to medical judgement in times of sickness and stress. See Charles Foster, *Choosing Life, Choosing Death* (Oxford, NY: Hart Publishing, 2009) at 6-11; Willard Gaylin & Bruce Jennings, *The Perversion of Autonomy: Coercion and Constraints in a Liberal Society* (Washington, argue that even accepting autonomy as the pre-eminent value, the prolific legalism which has developed around the concept of informed consent has facilitated an overemphasis of it, which can potentially result in a paradoxical hindrance of autonomy. For instance, Roger Brownsword has argued that one can properly endorse a "culture of consent" in order to advance autonomy interests, but cautions against the development of the "cult of consent", which he believes has already appeared in some aspects of Western culture.[207] The cult of consent—an overvaluation of informed consent, exists where the given community becomes inordinately transfixed upon it. As a result of this tunnel vision, the acquisition of informed consent dominates all other ethical considerations, we are paralyzed to act without it, the standards for obtaining it tend to increase over time, and once it is obtained, we are inclined to attribute an unrealistic degree of mental capacity on the part of the consenting party as we hold up their consent form as evidence of our due diligence. As a result, informed consent becomes both the necessary and sufficient *pro forma* justification for medical intervention, potentially detached from or even contrary to the values which it was created to serve: utility, human rights and a respect for dignity, and instead functioning as a formal record which will limit liability on the part of the medical practitioner.[208] This kind of thinking and the legalistic frameworks which develop from it curtails any inquiry into whether or not the proposed intervention would actually serve other important values and, in particular, the autonomy of the individual in question, and instead focuses the concern on whether or not the medical practitioner has adequately protected their own interests by obtaining sufficient consent.[209]

When one ponders the notion of informed consent as it relates to medical interventions, it becomes dubious whether or not merely abiding by one's expression of a choice is really acting in furtherance of their autonomy. Indeed, equating an expression of choice with autonomy may simply conflate autonomy with self-ownership, independence, bodily integrity, and freedom from

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DC: Georgetown University Press, 2003). However, as Tauber points out, unlike other bioethical principles (eg beneficence, non-maleficence, justice) simply do not lend themselves to codification, thus leaving autonomy as being the default value upon which legislation can be structured. See Tauber, *ibid* at 486-488.

[207] Roger Brownsword, "The Cult of Consent: Fixation and Fallacy" (2004) 15 KCLJ 223.

[208] *Ibid* at 224-230. Brownsword also cautions against a legalistic undervaluation of consent, in which it is simply presumed or impliedly given, such as is the case in British Columbia's legislation concerning involuntary psychiatric treatment.

[209] Brownsword argues likewise, that informed consent as an ethic in and of itself is fallacious as it would hold that any action which is consented to cannot possibly be wrong, and any action that is not consented to must be wrong since there could not possibly be any other justification for it. *Ibid* at 250.

interference, which are related but arguably distinct concepts.[210] I follow this line of thinking and argue that the ideal of autonomy cannot merely be grounded in the principle of informed consent by itself, and I agree with David Archard, that many of the "wrongs" associated with breaches of informed consent principles are not really about a lack of respect for autonomy, but are in fact breaches of the principle of self-ownership.[211]

It is now commonly accepted that the proper physician-patient relationship is one defined by collaboration and an emphasis on trust. Thus, while it is uncontroversial that one of the fundamental tenets in medicine is still that which was established in the Hippocratic tradition--"do no harm", what has been understood to constitute "harm" has evolved over time. What was once a conception of harm based on sickness and injury, which was remedied by medical paternalism, has now shifted towards an emphasis on personal integrity and autonomy.[212] Nevertheless, the conceptualization of autonomy in the healthcare context must strive to be practical and realistic, allowing us to recognize and respect personal autonomy where it exists, while simultaneously avoiding overestimating it and consequently showing unwarranted deference to patient preferences, especially where such deference is contrary to their medical best interest.[213]

C. Personal Autonomy in Philosophy and Ethics

In this section I will briefly outline the philosophical development of the moral value of autonomy which has led to its current formulation and emphasis in law and moral theory.

1. Traditional Individualistic Theories of Autonomy

One of the earliest accounts of autonomy which bears a resemblance to the autonomy of today's discourse was that espoused by Immanuel Kant. Kant's conception of autonomy was

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[210] See David Archard, "Informed Consent and the Grounds of Autonomy" in Thomas Nys, Yvonne Denier, and Toon Vandevelde, eds, *Autonomy & Paternalism: Reflections on the Theory and Practice of Healthcare* (Dudley, MA: Peeters, 2007) 113 at 114-118.

[211] *Ibid* at 127.

[212] McLean, *supra* note 205 at 11-13.

[213] See Onora O'Neill, "Paternalism and Partial Autonomy" (1984) 10:4 Journal of Medical Ethics 173. O'Neill argues that autonomy as a value, especially when it is instantiated through the requirement of informed consent in the medical ethics context, has risen in value as our trust in individuals, institutions, and professionals has waned. In legalistic, rights-based societies such as ours, trust in the beneficence or tendency for others to act in our best interests or to do good for us has been eroded. This has occurred for many reasons, including the general emancipation of patient rights, the fact that the medical establishment has seen a number of atrocities and ethical lapses occur in the past century, leading to a decline in trust in the paternalistic or beneficent actions of health professionals, and the increase in legal regulation and oversight of the medical profession. See Onora O'Neill, *Autonomy and Trust in Bioethics* (Port Chester, NY: Cambridge University Press, 2002) at 1-15.

instrumental to his deontological answer to the problem of determinism. In order to ascribe moral accountability for our actions, Kant posited that our ability to self-govern through rational thought and choice-making was what made our actions morally praiseworthy or blameworthy.[214] To be autonomous is to govern ourselves with principles that most express our nature as free and rational beings.[215] One lacks autonomy on this account not only if they are influenced by external pressures, such as law, authority, or peer pressure, but also if one's *own* desires compel choices that are at odds with his rationality. For Kantian autonomy to subsist, it must derive solely from the individual's rationality.[216] If it appears that one's choices are not purely rational and are being influenced by external or internal compulsions, we might question the degree of respect, if any, such choices should be afforded.

John Stuart Mill's theory of autonomy moved beyond the focus of autonomy as pure rationality and placed emphasis on the individual's actions and desires.[217] Mill's utilitarian view of autonomy was that it was necessary to an individual so that he might maximize his own good, with the proviso that it should not be exercised in a manner which would injure others. Like Kant, there is emphasis on self-governing here, however this conception recognized the importance of an individual's ability to set their own course of action in accordance with their internal desires, which, unlike Kant, were not seen as impediments to the exercise of autonomy, but rather constitutive of it.

Mill's views on autonomy gave rise to various hierarchical accounts as well as the refinement of concepts of "authentic" autonomy. While there was much agreement as to the necessity of desires informing autonomous choices, there was a need to distinguish "legitimate" desires from ones that were merely compulsive or ill-informed, which intuitively serve as impediments to autonomous action. For instance, a smoker's desire for cigarettes might inform

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[214] Owen et al, *supra* note 8 at 83. See T L Beauchamp and J F Childress, "Principles of Biomedical Ethics" 2nd ed (New York: Oxford University Press, 1983) 59 at 60- 65.

[215] See John Rawls, "A Theory of Justice: Rev Ed" (Cambridge, MA: Belknap Press of Harvard University, 1999) at 222, 452; Henry Sidgwick, "The Methods of Ethics" 7th ed (Indianapolis/Cambridge: Hackett Publishing Company, 1981) at 57-59.

[216] Naturally, since autonomy and rationality are so intimately linked, and one presumably values his own rational autonomy, the categorical imperative demands that he must also respect the value in the rational autonomy of others, which gives rise to the requirement to respect the autonomy of others. See Immanuel Kant, "Grounding for the Metaphysics of Morals", in I Kant, *Ethical Philosophy*, James W Ellington, trans, (Indianapolis, IA: Hackett Publishing Co., 1993, 1875).

[217] See John Stuart Mill, "On Liberty" in *Utilitarianism/On Liberty/Essay on Bentham*, edited by M Warnock. (Glasgow: Fontana Press, 1990).

their choice to smoke, however their desire may be unduly influenced by their addiction, and/or contrary to another desire they have to quit smoking. Harry Frankfurt's hierarchical conception of autonomy provides an example of a way in which philosophers have attempted to address this conundrum. Frankfurt distinguishes between first order and second order desires and argues that one must possess consistent first and second order preferences for a choice in order for that choice to be considered truly autonomous. In this respect, a person who wants to eat an apple (a first order desire) *and* who wants to have the apple-eating desire (they wish to eat healthy foods – a second order desire), is autonomous in their apple-eating. Conversely, a person who wants a cigarette (first order desire) but does *not* want to want it (because smoking is unhealthy and they would prefer to quit – a second order desire) and yet smokes anyway, is not autonomous in that action.

It is not difficult to find fault with such hierarchical theories of autonomy. First, there is the practical difficulty of recognizing and assessing the impact of second-order values. For instance, in the case of mental illness, how are we to tell to what extent, if any, an individual's expressed second-order value is being impacted by their illness? Second, and more substantively, is the concern that these theories may not address the validity or source of the second-order values; arguably, at least in some cases, we should care about the origin of the person's second-order values. For instance, in the case of mental illness and psychiatric treatment, a patient may, as a result of their illness, develop a second-order treatment refusal desire (for instance, they may develop a pervasive paranoia which makes them distrustful of doctors or medication) which would automatically align and justify as autonomous all of the resulting first-order desires involving refusing medication, their decisions to leave the hospital, and the like. It seems reasonable to say that the individual is not acting autonomously by refusing the treatment, and our reason would likely be purely that we think the source of the preference (to refuse treatment) is not legitimate.[218]

In order to address the problem of judging the source of second-order desires, or other preferences which inform our decision-making, we can appeal to various procedural safeguard requirements. As will be discussed in greater detail below, we must strike the correct balance between refraining from judging a person's values and condemning them as non-autonomous merely because we do not approve of them, versus the need to hold such values to some basic standard of legitimacy of origins. One way to do this, as Gerald Dworkin suggested, is to assert a

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[218] Harry Frankfurt, "Freedom of the Will and the Concept of a Person," in Harry Frankfurt, *The Importance of What We Care About*, (Cambridge: Cambridge University Press, 1987).

requirement of procedural minimum standards for the generation of legitimate preferences. For Dworkin, this was the requirement that an individual critically reflect on their beliefs and endorse them in the absence of any external constraints. Changing one's belief gradually over time is possible, however they must be able to coherently reflect on the evolution of their beliefs.[219]

In the bioethical discourse Beauchamp and Childress may be credited with defining the most prolific conception of autonomy, albeit that it has been strongly critiqued, as will be discussed below. Beauchamp and Childress developed the medical ethical framework referred to as "principlism", which consists of four guiding medical ethical principles which must be adhered to by practitioners: beneficence, non-maleficence, justice (individual and distributive justice amongst the population overall), and respect for persons (autonomy).[220] This last requirement—respect for persons—requires a respect for the decisions made by individuals, which is in turn described as self-rule or self-determination, free from external constraints, interference, or limitations, such as inadequate understanding. In essence, respect for persons is a predominantly negative right as it requires non-interference with the decision maker's preferences for how they will be treated.[221]

Gaylin and Jennings describe this understanding of autonomy as constituted by both a positive and negative element, however. The negative element entails a zone of privacy and non-interference with the individual, where autonomy is "an ideal of selfishness or disorderly self-indulgence, … always self-centered, self-expressive, and individualistic…".[222] In the positive

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[219] See Gerald Dworkin, *The Theory and Practice of Autonomy*, (New York: Cambridge University Press, 1988).

[220] It has been pointed out that although autonomy is one of four elements of principlism, the other three each of the others relies on the notion of a rational autonomy agent, which in turn presumes the presence of certain predominantly Western normative values (a capacity and desire for individualistic self-government, self-interest, rationalist thinking, etc.). These values may not obtain across all cultures and times, and others have argued the need for more culturally sensitive theories of bioethics. Others have argued that principlism as being "thick in status, thin in content" – principlism is supposed to be a practical guide to common morality, yet it admits of a legitimate moral diversity, meaning that it can essentially be employed in tandem with whatever the *de jure* morality happens to be. Principlism therefore loses some of its practical functionality as a streamlined analytical ethical tool as it can be applied to any a plurality of moral beliefs and is thus unable to give the "right" answer when it accepts many answers as right. I will not pursue this literature, instead focusing on feminist critiques of this conception of autonomy. See Stuart J Murray and Dave Holmes, *Critical Interventions in the Ethics of Healthcare* (Abingdon, Oxon, GBR: Ashgate Publishing Ltd, 2009) at 3; Marvin J H Lee, "The Problem of 'Thick in Status, Thin in Content' in Beauchamp and Childress' Principlism" (2010) 36 J Med Ethics 525.

[221] Beauchamp, Tom & James F Childress. *Principles of Biomedical Ethics*, 6th ed (New York: Oxford University Press, 2009). See also Yvonne Denier, "Autonomy in Dependence: A Defence of Careful Solidarity" in Thomas Nys, Yvonne Denier, and Toon Vandevelde, eds, *Autonomy & Paternalism: Reflections on the Theory and Practice of Healthcare* (Dudley, MA: Peters, 2007) 93 at 95; J F Childress, "Who Should Decide? Paternalism in Health Care" (New York: Oxford University Press, 1982).

[222] See Willard Gaylin & Bruce Jennings, *supra* note 206 at 72.

sense, autonomy is a self-mastery and a desire for one's choices to reflect an internal "self".[223] Since it is easier to legislate negative rights of non-interference than to establish rules for promoting the positive ideal of autonomy, it is the former which receive legal attention and which are resultantly enshrined as rights and in law. This feeds back into the dominant culture, and the right to autonomy is thus primarily recognized as being negative, concerned with individuals' freedom and independence from unwanted interference by others, as is plainly visible in the *Charter* jurisprudence discussed earlier. Beauchamp and Childress' conception of autonomy comes closest to Kant's autonomy, except that unlike Kantian autonomy, which would authorize paternalistic overrides of patient preferences when such preferences are not the product of the morality and rationality of the individual, paternalistic intervention is far more circumscribed in the autonomy of principlism.[224] Where principlism is concerned, respecting individual autonomy becomes synonymous with respecting the expressed choice of the individual, potentially without paying any mind to what factors are motivating the choice, as it is seen in the bioethical sphere as inappropriate to pass judgment on the patient's preferences in regards to treatment.[225]

2. *Critiques of the Traditional Individualistic Concept of Autonomy*

Criticism of the traditional conception of autonomy in bioethics has been prolific. Many of these critiques have origins in feminist critical theory, however different commentators raise different concerns.[226] One common critique is that personal autonomy's focus on individualistic, self-interested, rational self-government is simply an impoverished, inaccurate account of how people make decisions. It therefore follows that the traditional individualistic account of autonomy represents an inappropriate conceptual benchmark for legislating on matters of consent, freedom from interference, and the like.

Stirrat and Gill have argued that the conventional individualistic approach to understanding and maximizing patient autonomy in the medical context has functioned largely to replace medical

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[223] *Ibid* at 41.

[224] See Aaron E Hinckley, "Two Rival Understandings of Autonomy, Paternalism, and Bioethical Principlism" in H. Tristram Engelhardt, ed, *Bioethics Critically Reconsidered: Having Second Thoughts* (2012) 100 Philosophy and Medicine 85; Immanuel Kant, "The groundwork of the metaphysics of morals" in M Gregor and A Wood, eds, *Practical philosophy*, (New York: Cambridge University Press, 1996). See John Rawls, *supra* note 215 at 222, 452.

[225] For the most part, mental competence becomes the predominant factor in determining whether or not a medical decision ought to be respected.

[226] While feminist critiques often center on concerns of class and in particular the status of women, the feminist critique remains particularly relevant to the issue of autonomy in mental health because it challenges mainstream definitions of autonomy as well as the presumptions which underlie theories of informed consent.

paternalism with "bioethical paternalism", potentially sacrificing the patient's medical well-being in favour of their treatment preferences—their autonomy.[227] The flight away from the "doctor knows best" view of the doctor-patient relationship is thus replaced with "the patient is always right" view, which many argue is an equally flawed and inappropriately deferential approach to patient preferences. The problem is in the sole focus on the individual's right to be free from unwanted interference, replacing the principle of beneficence (doing good for the patient) with autonomy (giving them what they want). Arguably, neither principle should be the sole factor in dictating the happenings within the physician-patient relationship.

Marilyn Friedman has also provided a useful critique of individualistic autonomy theory which speaks to the concerns which Dworkin and others have attempted to address insofar as assessing the origins of individual desires that may inform decision-making. First, one can distinguish between substantive (content-laden) versus procedural (content-neutral) autonomy. Substantive autonomy requires an individual choosing that which accords with their values, and with the value of autonomy in itself – choices that enhance freedom in decision-making as opposed to choices that limit it.[228] For example, a person choosing subservience or slavery would not be exercising substantive autonomy, no matter how much the individual approved of the decision, because their choice is drastically limiting their future options. In contrast, procedural autonomy exists only insofar as an individual's stated choices are respected, regardless of what values inform them and what considerations the individual undertakes in deliberating their choice.[229] Friedman is critical of policies based in procedural autonomy, since merely abiding by an individual's unreflecting, uncritical stated preference could potentially contribute to their own oppression or may do little to enhance their well-being *qua* agency, independence, and development of self. Most procedural accounts of autonomy, however, contain various requirements and measures in order to guard against at least overt oppression and interference. Procedural accounts of autonomy tend to emphasize an inquiry into the individual's capacity for decision-making, the presence of compulsive forces, and the adequacy of information available to the decision-maker. So long as

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[227] GM Stirrat and R Gill, "Autonomy in Medical Ethics After O'Neill" (2005) 31 Journal of Medical Ethics 127.

[228] In this regard, substantive theories of autonomy may include prohibitions on certain choices, such as "choosing" slavery, subjugation, or other long term autonomy-limiting courses of action.

[229] Marilyn Freidman, *Autonomy, Gender, Politics* (New York, NY: Oxford University Press, 2003) at 19.

the individual's decision-making process is sound, the substance of their decisions should not be analyzed or criticized.[230]

The feminist critique addresses other potential faults which are often prevalent in procedural concepts of autonomy and which may even be present in relatively robust substantive accounts of autonomy.[231] These additional concerns include:

1) The traditional view of autonomy views a person as a coherent, unified subject with a stable identity persisting over time. In reality, a person's identity may be fragmented, unstable, and incoherent. A concept of autonomy which does not adequately account for this cannot track nor evaluate the enduring autonomy of an individual.
2) The traditional view of autonomy assumes an unrealistic level of transparent self-awareness. That is, the individual is aware of what their desires are and is capable of a high degree of critical self-reflection, thereby avoiding any self-deception or inadvertent adoption of potentially oppressive externally imposed values or choice-limiting circumstances.
3) The traditional view of autonomy holds reason as the preeminent value and decision-making factor and tends to be dismissive of values based in emotional thinking. This can lead to the conflation of decisions and actions based on pure reason, and decisions and actions which reflect the individual's true or authentic identity.
4) The traditional view of autonomy tends to examine autonomy without sufficient social context. The value-neutrality of procedural (content-neutral) understandings of autonomy may be appealing because it does not purport to judge a person's preferences when assessing their autonomy; however, this simultaneously diverts the inquiry and distracts us from seeing underlying autonomy-limiting forces. Even substantive concepts of autonomy which direct an inquiry into the coherence between the individual's core values and their decision-making may fail to take stock of the more subtle controlling influences on the decision in question.

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[230] See Gerald Dworkin, *supra* note 219; Robert B Young, *Personal choice: Beyond Negative and Positive Liberty* (London: Croom Helm, 1986).

[231] *Supra* note 229 at 82.

5) The traditional view of autonomy has so far not permitted an understanding of the role and prominence that relationships should and do in fact play in the development and exercise of individual autonomy.[232]

Considered together, these concerns share the common theme that individualistic theories of autonomy, even those that include substantive verification requirements (such as the capacity for critical self-reflection, coherence with one's values, etc.) are essentially unrealistic because they tend to ignore constraints and impediments to independence and agency that fall below a certain threshold of "obviousness".[233]

The traditional understanding of autonomy ignores the ways that health-care mechanisms "influence the development and demise of the capacity for personal autonomy".[234] Susan Dodds employs Diana Tietjens Meyers' procedural approach to autonomy to demonstrate that promoting personal autonomy in health care necessarily requires considerations of well-being that go beyond the agent's act of choosing in medical decision-making. She emphasizes that autonomy and choice ought not to be conflated – respect for one does not necessarily require nor evince the same level or kind of respect for the other.[235] Liberal theories of autonomy, especially those popularized by Kant and Mill, emphasize non-interference by the state or other actors as being essentially constitutive of autonomy. This liberal notion is also "rationalistic, atomistic, and individualistic".[236] Thus it is narrowly proscriptive as opposed to prescriptive—it does not focus on promoting or building autonomy, but merely protecting some unrealistic idealization of it, instantiated by the legal construct of informed consent. Quickly, due to the relative ease in applying tests of informed consent in law, autonomy is identified and sometimes synonymized with

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[232] *Ibid* at 82-92.

[233] Natalie Stoljar similarly notes that, while procedural accounts of autonomy place emphasis on addressing the mechanisms of decision-making, rather than judging the preferences and goals of the decision-maker, some substantive requirements must exist in a proper account of autonomy. This is because a purely procedural account of autonomy which required only some ability of critical reflection on the part of the decision-maker, would leave the decision-maker vulnerable to the more subtle and pernicious forms of oppression, and thereby limit their practical choices. See Natalie Stoljar, "Autonomy and the Feminist Intuition" in Catriona Mackenzie and Natalie Stoljar, eds, *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (Oxford, NY: Oxford University Press, 2000) 94 at 95.

[234] Susan Dodds, "Choice and Control in Feminist Bioethics" in Catriona Mackenzie and Natalie Stoljar, eds, *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (Oxford, NY: Oxford University Press, 2000) 213 at 214.

[235] *Ibid* at 215.

[236] *Ibid* at 216.

informed consent.[237] According to Dodds, respect for autonomy requires the "promotion of the development of autonomous selves".[238] In order to move beyond a purely atomistic view of autonomy, it is useful to consider feminist theories of relational autonomy.

3. Relational Autonomy

Jennifer Nedelsky advocates for a relational approach to understanding autonomy and represents one of the more prolific and recent commentaries in the autonomy discourse.[239] Nedelsky argues that autonomy is maximized in two necessary steps: first, by uncovering all of the latent relational connections that exist between individuals and their environments; second, by adapting law and social policy to create an environment which fosters autonomy-promoting relations as opposed to autonomy-limiting relations.[240]

To explain the difference between autonomy-promoting and autonomy-limiting relations, Nedelsky employs the example of the structuring of entitlement criteria for social assistance payments. She argues that financial dependence on the state is not in and of itself destructive to autonomy, provided the relation between the state and the individual receiving assistance is not one of domination. Payment criteria which are autonomy-limiting would be those that restrict payment to individuals whose income is negligible, while reducing or denying assistance to those whose income is higher yet still insufficient to elevate them from circumstances of poverty, as this would be punishing the individual who attempts to better themselves, find a higher paying job, and achieve a measure of independence. The individual is incentivized not to work and not to become independent, as the assistance regime may actually make them worse off if they attempt to do so. Similarly, assistance regimes based on principles of "workfare" or which require the recipient to undertake onerous burdens or which restrict the use of the assistance funds may limit the recipients autonomy if the result is that the individual is trapped in a cycle of receiving "just enough" to get by but is so burdened by the obligations placed on them that they cannot extricate themselves from the cycle of poverty. Conversely, support payments which have reliable payment schedules and

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[237] *Ibid* at 217.

[238] *Ibid* at 227.

[239] Jennifer Nedelsky, *Law's Relations: A Relational Theory of Self, Autonomy, and Law*, (New York: Oxford University Press, 2011) at 36, 46.

[240] *Ibid* at 65-66.

which incentivize and meaningfully facilitate skill development or other steps towards independence, would be considered autonomy-enhancing.[241]

Nedelsky conceives of relations as including two principal groupings: personal relations—relations between people, and "wide-pattern" relations—those relations between people and institutions (society, the law, etc.) or between people and social categories, such as gender, race, socioeconomic status, etc.[242] An individual's myriad relations with other people, society's institutions, and systems, and social classes, norms, and culture, informs the options which the individual has available to them, the systems of rewards and punishments, incentives and disincentives, and opportunities that they will have or be subject to. Nedelsky has aptly described the distinction in motivation between the traditional and relational conceptions of autonomy, noting the different presuppositions in each. She summarizes that individualistic ideas of autonomy, harkening back to Kant and Mill, were designed to keep the state out of the personal lives of its citizens by "building walls of negative individual protections"; however, this ignores the reality that the state has already penetrated the person by implementing laws, policy, and systems of rights, all of which impact the individual's life, development of capacities, and choices. In contrast, if we endeavour to understand the relational aspects of law and policy, recognizing the pre-existing impact they have on individuals' choices and capacities, we can ensure that this law and policy functions to empower our decision-making capacities.[243]

Even where new laws and policy are not overtly autonomy-limiting in the sense which Nedelsky describes, the failure to consider their relational aspects may result in an overestimation of individual autonomy and the loss of an opportunity to enhance an individual's autonomy. Sherwin aptly points out that "[i]ndividualistic interpretations of autonomy seem to suggest that medical consumers should be provided with whatever services are voluntarily chosen…but a relational understanding of autonomy requires that we raise questions about the context of those choices"[244] In the case of treatment refusals by marginally competent individuals, the refusal may be informed by more overt influences from the mental illness itself, and not only by subtle forces of oppression *per se*, however the situations are analogous, insofar as we have reason to be

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[241] *Ibid* at 65.

[242] *Ibid* at 20.

[243] Jennifer Nedelsky, Relational Autonomy and the Law (Workshop delivered at the Faculty of Law, McGill University, 23 November 2012) [unpublished].

[244] Susan Sherwin, "A Relational Approach to Autonomy in Health Care" in Elisabeth Boetzkes & Wilfrid J Waluchow, eds, *Readings in Healthcare Ethics* (Peterborough, ON: Broadview Press Ltd, 2000) 69 at 83.

concerned that the choice expressed by the individual may be impacted by internal or external constraints which they appear not to be aware of. For instance, Scott Starson experienced delusional and disordered thinking, but was nonetheless determined to be mentally competent, and by implication, would be deemed to have made an autonomous choice. In essence, because he "understood and appreciated" the proposed treatment, and declined anyway, that ended the inquiry. Yet a more nuanced analysis, taking stock of all of his symptoms and the way in which they inform his preferences, would surely indicate that, his delusions and disordered thinking played a significant role in his decision-making process.

McLeod and Sherwin argue that traditional dialogues on autonomy focus on overt hindering factors, such as coercion, internal compulsion, and ignorance – essentially those things which interfere with informed consent, but often overlook the impact of more systemic and subtle oppressive mechanisms.[245] They also agree that a relational critique of autonomy will help expose the subtle oppressive forces that impact a person's autonomy.[246] I agree, and argue that psychiatric treatment, in certain circumstances, can be viewed as a tool for promoting autonomy and/or redressing currently existing impediments to autonomy. For instance, the use of therapy, whether pharmaceutical or otherwise, may be part of enhancing the decision-making capacity of the individual, at least on a short term basis, as their ability to think clearly, articulate themselves, and understand more complex information, may be improved with treatment. This, in turn, enables more independent thinking and actions, however, without a proper and rigorous analysis as to the capacity of the individual and the legitimacy of their stated wishes in regards to treatment, premature or automatic resort to pharmacotherapy with a view to "enhance their decision-making" would be tantamount to the strong paternalism which the relational analysis should assist in avoiding.

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[245] Carolyn McLeod & Susan Sherwin, "Relational Autonomy, Self-Trust, and Health Care for Patients Who Are Oppressed" in Catriona Mackenzie and Natalie Stoljar, eds, *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (Oxford, NY: Oxford University Press, 2000) 259. McLeod and Sherwin thoroughly discuss the ways that the environment as well as social support (or lack thereof) can enhance or limit personal autonomy. This discussion is not pursued because it is peripheral to the medico-legal aspects of autonomy.

[246] Arguably, the impact of mental illness is often not subtle, however our response to it can still be informed by the relational critique, insofar as alternate treatment options may be illuminated. For instance, by understanding that one's autonomy is partially a function of their own self-trust and knowledge, providing decision-making supports, information, and encouraging self-directed decision-making may help elevate an individual's ability to make decisions. *Ibid* at 267-269.

D. Critique of the Relational Account of Autonomy

Before concluding on the philosophical discourse on autonomy and moving into autonomy *vis à vis* the mental health context, it must be noted that relational autonomy concepts are subject to criticism as well. One substantial critique is that, for all the nuance that a relational analysis promises to add to the analysis of an individual's autonomy, it is still the case that such analyses cannot distinguish between individuals who should be protected from paternalistic interventions and given substantial deference in decision-making, from those that should not. Furthermore, the relational analysis may not result in any practical prescription for change in certain cases. In sum, the relational analysis may be limited to highlighting possible sources of oppression or limitations on an individual's decision-making capacity, but cannot necessarily indicate that such limitations require redress, and if even if they do, what should be done about them.[247]

For instance, in the case where a patient must give informed consent to a medical procedure, we can imagine many factors which would impact the patient's capacity for autonomy in making this decision, including her education, her history of dependence versus independence, her marital status, her class, her faith, etc. Yet after all of the relational analyses, whether the patient appears totally liberated or totally oppressed, or anywhere in between, so long as she is mentally competent, her stated decision must be respected. Few would argue that a patient who is highly oppressed ought to be further oppressed by having her physician's disregard her choices in favour of acting paternalistically towards her.

It may be that relational analyses are more suited to informing macro-level policies, insofar as autonomy and independence can be enhanced in the long term, proactively. Yet even in short term situations such as in the case of a single patient making a medical decision, a relational analysis can, at minimum, shed light on further avenues of inquiry. For instance, a physician seeking informed consent from their patients may attenuate the level of engagement with each patient. In cases of educated, informed, and independent, patients, a single brief explanation may suffice; while in cases of patients with less education, who seem unable to make firm decisions,

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[247] Jules Holroyd, "Relational Autonomy and Paternalistic Interventions" (2009) 15 Res Publica 321. Others, such as John Christman, point out that it is problematic "to claim that being autonomous *means* standing in proper social relations to surrounding others and within social practices and institutions … [because this] turns the concept of autonomy into an unacceptably perfectionist idea that carries with it the danger of exclusion and overarching paternalism that attention to autonomy should well protect against." See John Christman, "Relational autonomy, liberal individualism, and the social constitution of selves" (2004) 117 Philosophical Studies 143 at 158. For additional critiques of relational autonomy, such as its prima facie dismissal of selfish decision-making, see Sheila A M McLean, *Autonomy, Consent and the Law* (New York: Routledge-Cavendish, 2010) at 27-32.

or who are subject to external compulsive forces, more extensive or alternative consultations may be advised.

The feminist critique has focused on these barriers as being primarily social or gendered in nature,[248] as well as impacting the individual's sense of self.[249] In a similar vein, it should be apparent that impairments to one's mental state, whether long term or short term, that fall below the threshold of constituting legal incapacity, can nonetheless impact an individual's decision-making process. It follows that if we should take seriously the concerns expressed by the above commentators regarding the autonomy-limiting social relations that erode or distort relational autonomy, we should also pay attention to the impact on autonomy caused by mental health issues.

E. **Autonomy in the Mental Health Context**

The concept of autonomy takes on numerous complicating tones when it is applied and identified in the case of people with certain mental illnesses.

Psychiatric hospitalization inherently entails a loss of control and autonomy for the patient. This is so, regardless of whether or not the hospitalization is voluntary or not, as Paul Christopher has explained using numerous narrative accounts of such events.[250] Even in circumstances where a patient purportedly accepts hospitalization on a voluntary basis, there may be some element of coercion present, or some residual worry that once they enter the system, they will find it difficult to exit it. After all, most psychiatric units are locked, patient activities monitored, some patients detained unwillingly, and an often lengthy assessment procedure in order to be released, a psychiatric hospital may indeed resemble a prison.[251] Thus, whether based on their own or others' previous experience with the mental healthcare system, some may come to believe that refusing admission or treatment, regardless of potential ensuing deteriorations in health, is the best way to maintain their autonomy. They reason that by avoiding the mental health care system and what might be a lengthy cycle of assessments, substitute decision mechanisms, and increasing and varying medications and side-effects, they will actually have more control in their life. Christopher argues that "rather than simply being "in denial" or "resistant" to care, these individuals may be

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[248] Susan Sherwin, *supra* note 244.

[249] For in depth discussion on the interface between feminist and communitarian theories underlying relational autonomy and the sense of self, see Christman, *supra* note 247.

[250] Paul P Christopher, "Psychiatric Hospitalization—Bridging the Gap Between Respect and Control" (2011) 1:1 Narrative Inquiry in Bioethics 29.

[251] *Ibid* at 32.

making a difficult but, from their perspective, rational choice to just 'stay away.'"[252] If this is so, then it will be ever more important not to attribute the "resistance" to treatment as merely an outcome of a person's mental illness, rather, it is a preference, perhaps not unlike a preference to forego the pain and associated ordeals of chemotherapy, merely to extend one's life a while longer.[253]

The development of autonomy in psychiatric bioethics is also stymied by the law. The legalism which defines mental health treatment arguably further entrenches the individualistic conception of autonomy in bioethics.[254] The result is a relative neglect of mental health issues in the bioethical discourse. Since the usual reliance on informed consent procedures is problematized by the presence of mental illness, legislators create Mental Health Acts to govern a separate method of treating people with mental illness. Health care practitioners therefore need only adhere to this legislation, rather than develop their own policies and practices for promoting the welfare of psychiatric patients.[255]

Not all mental illnesses impact a person's ability for autonomous decision-making. Diagnosing mental illness is often a difficult task, as the symptoms of one disorder may resemble that of another. Yet even if diagnostic precision is achieved, it still does not follow that having a mental disorder will necessarily impact the person's autonomy, so construed in the Western legal and clinical sense, since the illness may not bear on the patient's ability to understand, appreciate,

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[252] *Ibid* at 30.

[253] Similarly, Susan Stefan suggests that competence is relational, contextual, and defined by the communication which takes place between two people, as opposed to being a phenomenon which only measures the decision-making capacity of an individual. That is, "[l]ack of competence is perceived, assessed, and judged by others. Competence inquiries generally arise in the context of some form of breakdown in communications. These communications are largely about values." See Susan Stefan, "Silencing the Different Voice: Competence, Feminist Theory and Law" (1993) 47 U Miami L Rev 763 at 781.

[254] Some take a more pragmatic view of the legalism of mental health law. For instance, some commentators argue that the *Starson* case is not significantly going to change clinical outcomes in Canadian involuntary mental health treatment. Rather, it will just change clinical practice such that psychiatrists will just gather (or interpret) more and better evidence when making a capacity assessment. This may simply amount to a few extra questions and more thorough note-taking, and will not actually prompt a shift towards a lowering of the standard of mental competence. See S A Brooks, R L O'Reilly, and J E Gray, "Implications for Psychiatrists of the Supreme Court of Canada *Starson v Swayze* Decision" Canadian Psychiatric Association Bulletin (August 2003), online: http://ww1.cpa-apc.org:8080/publications/archives/Bulletin/2003/august/brooks.asp..

[255] See Janet R Nelson, "Bioethics and the Marginalization of Mental Illness" (2003) 23:2 Journal of the Society of Christian Ethics 179.

and reason in relation to the disease.[256] Therefore, the mere presence of mental illness must not lead us to undervalue a person's autonomy.

On the other hand, Gaylin and Jennings critique of, what is in their view, the over-valuation of autonomy, highlights the fact that the most marginalized segments of society, including the homeless mentally ill, have been left to deteriorate and languish in the name of respecting their autonomy.[257] Gaylin and Jennings are critical of the readiness by which some treat those with serious mental illness as having normal levels of autonomy, and they describe such situations as a sacrifice of the individual's well-being to the illusion of their autonomy.[258] The reasons for the preference of autonomy to beneficence, though complex, are forcefully articulated by Gaylin and Jennings as being that

> [t]he culture of autonomy has emerged gradually out of the underlying forces of individualism, secularization, materialism, and rationalism that have defined modernity in the West. … When people support public policies and social practices that maximize personal freedom of choice, no matter what the moral or financial cost to society and no matter how self-destructive the behavior, they are responding to the seduction of autonomy … Rejection of commitments, relationships, discipline, and duty are openly celebrated.[259]

What results from this kind of thinking and valuation of autonomy is an unrealistic conception of individuals with mental illness as being rational and autonomous. Despite psychiatric evidence to the contrary, there is a tendency amongst some of the most liberal traditions to nonetheless regard everyone, no matter how mentally compromised, as being unencumbered by external forces, and having total authority over their actions. This creates "a society of rights without duties or obligations; of authority without responsibility".[260]

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[256] See Eric Matthews, "Is Autonomy Relevant to Psychiatric Ethics?" in Thomas Nys, Yvonne Denier, and Toon Vandevelde, eds, *Autonomy & Paternalism: Reflections on the Theory and Practice of Healthcare* (Dudley, MA: Peeters, 2007) 129.

[257] This is due in large part to the de-institutionalization movement, in both Canada and the United States, of the 1950's through 1970's, where the prevailing thinking was that since institutions were prison-like and was not "curing" them anyway, it is better that the mentally ill be "free" to be homeless on the streets. Gaylin and Jennings*, supra* note 206at 190-193.

[258] *Ibid* at 200- 201.

[259] *Ibid* at 252.

[260] *Ibid* at 203. The authors cite a real example of this phenomenon, wherein a former graduate student, now in the midst of symptoms of schizophrenia, is left untreated on the grounds that he is autonomously refusing treatment. He lives in a barn for fear that the FBI are after him and will apprehend him and put electrodes in his brain. He adamantly refuses to enter the District of Columbia, where much of his personal life used to be, since that is where the FBI are based. Although he is technically "free" from being treated, he is instead trapped outside of his personal life, and "forced" to live in a barn due to his paranoid delusions. Thus the illusion of his autonomy is preferred to beneficence of treatment, which may have actually lead to a restoration of his actual autonomy if his delusions were abated and he were free to return home. *Ibid* at 201.

Following the arguments of Gaylin and Jennings, I believe that the most significant concern for autonomy in the context of mental illness is the potential for the symptoms of the illness to moderate the preferences of the individual. Psychotic disorders such as schizophrenia or others which produce delusion and false beliefs are the most serious kinds of mental disorder, both contingently, because they are associated with earlier death, suicide, and homicide, and constitutively, in that the delusions may precipitate a loss of insight, rationality, and autonomy.[261]

As some commentators argue, when a person with a mental illness is having their capacity assessed, it is probable that at least some weight is being given to their evaluative commitments—their priorities and values—and that it is not in actuality a pure assessment of their reasoning capacities. This may or may not be purposeful, as evaluators themselves may be unable to disentangle the content of a belief from the reasoning which informs it. On the other hand, based on the forgoing discussion of substantive (content-laden) autonomy requirements, such as those proposed by Dworkin or Friedman, as well as Nedelsky, Sherwins, and Dodd's illustrations of the subtle and overt relations which may shape or restrict an individual's autonomy, it is arguably reasonable to question whether or not the evaluative commitments of an individual are functioning to limit their autonomy. In any event, whether by design or by inadvertence, if we will be judging the content of the patient's beliefs, and not just how they are formed, then we need to seriously discuss how we are to assess these substantive patient values in a way which will minimally impact their assessment of mental capacity.[262]

This challenge is evident and illustrated when considering the contrast in both the intuitive and clinical assessments of patients who, for instance, refuse life-saving blood transfusions for religious beliefs, refuse to maintain a normal body weight because they suffer from anorexia nervosa and their perceptions their own physical beauty are distorted, or refuse psychiatric medication because they prefer to live with the symptoms of the illness. Each refusal of medical intervention is based on a substantive evaluative commitment or preference, which may be impacted to some degree by mental illness and/or indoctrination. In some cases we may be likely to consider the external constraint as negating the individual's autonomy, while in other cases we may view the constraint as any other legitimate consideration which the individual weights in their

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[261] KWM (Bill) Fulford & Lubomira Radoilska, "Three challenges from delusion for theories of autonomy" in Lubomira Radoilska, ed, *Autonomy and Mental Disorder* (Oxford, NY: Oxford University Press, 2012) 44 at 46.

[262] See Jules Holroyd, "Clarifying capacity: value and reasons" in Lubomira Radoilska, ed, *Autonomy and Mental Disorder* (Oxford, NY: Oxford University Press, 2012) 145.

decision-making process. We must determine which preferences and circumstances legitimately inform a capacity assessment, and which do not.

The real question is, ethically speaking, how do we deal with treatment decisions made by those suffering from a mental illness, when, as Lillehammer describes, the individual may be psychologically "capable of forming, expressing, and acting on judgements about what is in their best interests, but [they] systematically fail to either judge well about their own self-interest or to successfully translate such judgments (well-founded or otherwise) into prudentially coherent plans or actions."[263]

F. Conclusion

While the philosophical understanding of autonomy has developed within moral philosophy and within the bioethical discourse itself, there has been less development in the legal context with regards to health law and in particular, Canadian law concerning involuntary treatment of mental illness. The processes of assessing competency and obtaining informed consent function as verification criteria for the respect of the individual's autonomy, which the Supreme Court has clearly established and enshrined in the common law and the Canadian *Charter*. Depending on how we understand this value of autonomy, however, will determine the proper implementation and role of competency assessments and informed consent in the context of psychiatric treatment.

Contemporary critiques of autonomy, such as that of Nedelsky and other relational autonomy theorists, demonstrate the limitations with an "all of nothing" approach to autonomy *qua* mental competency. To extend relational thinking about autonomy in the context of mental health treatment, we ought to formulate law and policy which facilitates autonomy-promoting relations for those with mental illnesses. However, we must be careful to construct a system which would not be overbroad in its reach so as to legitimize such measures being taken against anyone who simply has different values or preferences concerning treatment.

Based on the forgoing analysis, a key consideration is the balance that must be struck in the implementation of law, with respect to procedural versus substantive conceptions of understanding. It is clear from both the more modern bioethical discourse centering on individual

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[263] Hallvard Lillehammer, "Autonomy, value, and the first person" in Lubomira Radoilska, ed, *Autonomy and Mental Disorder* (Oxford, NY: Oxford University Press, 2012) 192 at 195.

autonomy, as well as the feminist critique of the traditional concept of autonomy, that a purely procedural account of autonomy would be deficient. Yet, where it concerns the ability to consent to medical treatment, the law in most of Canada is mainly or totally procedural, insofar as the legislated and common law standards of mental competency is solely concerned with whether or not the individual can "understand and appreciate" the nature and consequences of the decision. However, as has been discussed, while this procedural approach has the laudable anti-paternalistic goal of allowing the individual to decide what is in her own best interests, this approach in and of itself cannot guarantee the long term autonomy of people who refuse psychiatric treatment and whose decision making capacity is being influenced by their illness, and did not, for instance, provide Scott Starson meaningful promotion of his autonomy.[264]

The next chapter in this work provides an answer as to how Canadian law could take a principled approach to involuntary treatment of mental illness, taking lessons from the considerations of autonomy discussed in this chapter, noting in particular the importance of fostering autonomy-promoting laws and policy.

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[264] Recall, for instance, that the law in Ontario permits for the "warehousing" of people who are dangerous (and who can therefore be involuntarily committed) but competent (and therefore who can refuse treatment).

CHAPTER 5: Narrative Approach to Involuntary Psychiatric Treatment

A. Introduction

When treating mental illness, the preferences of the individual are frequently at the center of conflicts over treatment. As the law on this matter is informed by the concept of autonomy, it is important that the law is guided by a robust understanding of it. The challenge is how to articulate a principled theory of involuntary psychiatric treatment which would provide compulsory treatment in those cases where an individual's autonomy can be enhanced in the long term, while refraining from compelling treatment for those whose genuine preference is to be untreated.

The final concluding chapter of this work proposes a conceptual framework for understanding and affording the proper level of deference the preferences of individuals in the case of psychiatric treatment. Having considered the framework of the various mental health treatment regimes which exist in Canada, and evaluating their impact on the individual mental health patient's autonomy, as discussed in chapter three, I argue that it becomes apparent that a novel approach to treatment would result in a net enhancement of the autonomy of the patient.

I borrow from the work of Craig Edwards, who has advocated for the inclusion of a narrative element in treatment deliberations concerning psychiatric patients who purport to refuse treatment.[265] In brief, this approach would permit involuntary treatment of *competent* patients who have been diagnosed with a mental illness (such as schizophrenia) in the limited circumstances where their refusal of treatment does not cohere with the balance of their own personal narrative, values, and preferences. Importantly, this balance is *not* to be understood as the result of tension between medical paternalism and individual autonomy; rather, it is an approach resulting from a more robust understanding of an individual's autonomy alone, or put another way, a tension between the short term and long term autonomy of the individual.[266]

As I described in chapter two, the subject at the heart of this discussion is a person suffering from schizophrenia who has a history of difficulties complying with their medication – the chronic cycler. In this case, the individual is *not* a serious or imminent danger to others and therefore

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[265] Craig Edwards, *supra* note 12.

[266] I take for granted that the challenge in respecting the individual's autonomy is one of balancing their own preferences with what is medically understood to be in their best interests, however it is understood that their personal autonomy is largely subsumed within their medical best interests.

cannot be held involuntarily for the protection of themselves or others; rather, the harms they will suffer from their illness and their poor decision-making during this period will be long term, such as the loss of social relationships, an inability to work or live independently, in increased potential for homelessness and victimization of violence, etc.[267] An alternate situation is one which would resemble the *Starson* case considered by the Supreme Court of Canada, wherein the individual *is* dangerous and therefore committed to an institution involuntarily, and yet because they are competent they are allowed to refuse treatment, and therefore remain institutionalized without treatment, where they may or may not deteriorate further.[268] In this situation, the individual is permitted to remain "free" from unwanted treatment but is instead left to "rot with their rights on" while institutionalized.[269]

In both of these situations it is plain to see that Canadian law as it is currently formulated embraces a content-neutral understanding of autonomy as confirmed by the Courts in *Starson* and various other cases. As such, legal autonomy is defined in the short term sense, as being freedom from contemporaneous treatment that is unwanted. This is different from understanding autonomy in the long term sense, which could be described as retaining more agency and having more significant options in life to choose from.

Using the involuntary treatment framework proposed by Edwards as a justification for certain limited psychiatric paternalism, I propose that there can be a purposeful trade-off between short term and long term autonomy, wherein short term autonomy (freedom from unwanted treatment) is sacrificed in order to gain more substantial long term autonomy - freedom from institutionalization, independent living, ability to maintain a career, improved social interactions, and freedom from comorbid illnesses or associated perils of mental illness, such as drug use or being a victim of violence.

B. The Narrative Element of Psychiatric Treatment Deliberations

In utilizing a narrative analytical framework, my aim is to describe a principled approach to distinguishing those cases where a competent person suffering from schizophrenia or some

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[267] S Leucht et al, *supra* note 52 at 319. See also M S Swartz et al., *supra* note 52.

[268] As discussed in Chapter 3, only in Ontario can a person be institutionalized on the standard of "dangerousness" yet remain untreated because they are still competent. However, it should be noted that temporary psychiatric holds or institutionalizations can still occur in other jurisdictions which would still decline to treat the person while they are competently refusing treatment.

[269] See Thomas Guthiel, *supra* note 128. See also R Solomon, et al., *supra* note 128.

similar mental illness, can be treated without their consent, from those cases in which their refusal of treatment should be respected.

A narrative analysis is used to identify a system which maximizes the long term autonomy of the patient, where autonomy is understood relationally.[270] Charon and Montello describe the role of narrative ethics as being a tool to analyze the patient's life before and after it has been interrupted by a significant health-related event, with a view to determining an appropriate resolution of it.[271] By analyzing the biographical history, values, decisions, and relationships that the patient has had over time, we can understand what manner of treatment or approach would "fit" best with their ongoing story, or narrative. Moreover, this helps us distinguish their stated preferences and values that are consistent with their story, from those that are not and which are more likely arising due to the internal and external pressures and influences of their illness.

The narrative approach to involuntary psychiatric treatment of marginally competent patients places emphasis on assessing the preferences and values of an individual over time, and relies on the understanding and acceptance of the idea that those values and preferences which are most consistent with a patient's narrative are the ones which ought to be afforded the most respect.[272] I describe this theory, as articulated by Edwards, in what follows.

In his essay, "Beyond Mental Competence", Edwards describes a principled theory which allows us to distinguish preferences, with respect to psychiatric treatment, that are *authentic* from those that are not. Edwards' takes as a foundational premise that those preferences which are authentic, as he defines it, are worthy of respect and deference, while those that are inauthentic are either not worthy or less so worthy.

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[270] Clive Baldwin, "Narrative, Ethics and People with Severe Mental Illness" (2005) 39 Australian and New Zealand Journal of Psychiatry 1022 at 1024.

[271] Rita Charon and Martha Montello, *Stories Matter: The Role Narrative in Medical Ethics*, (New York: Routledge, 2002) at xi.

[272] It is arguable that in the most general sense, any medical, psychiatric, or legal analysis of a patient's ability to consent to a proposed treatment utilizes a narrative component insofar as the patient's ability to comprehend the decision will be assessed contextually and on a case by case basis. For instance, as the generally uniform standard of mental competence previously requires that the patient understand and appreciate the nature and consequences of their decision, this would involve an inquiry into a number of biographical and situational factors, including, but not limited to: the overall intelligence of the patient, including cognitive, emotional, and social reasoning abilities, their history of treatment, their emotional state, their communication abilities, and any overt impairments to their cognitive abilities caused by their illness. In other words, a determination of contemporaneous competence is arguably not possible without a minimal understanding of the patient's background. I aim to explore a focused temporal aspect of a narrative analysis, examining the preferences of the patient over time.

Edwards is motivated by his belief that predicating involuntary treatment solely on whether or not the patient is mentally competent to consent to it or not is a deficient approach to the extent that it functions to sacrifice an individual's well-being in order to defer to an illusory sense of their autonomy. On the one hand, Edwards agrees that procedural or content-neutral accounts of autonomy are often viewed as more liberal and frequently preferred when considering patients' preferences because they do not judge the authenticity or worthiness of a decision based on the individual's preferences; rather, their decision is judged based on their decision-making capacity and so long as the capacity persists, the decision is given respect and liberal rights protections.[273] This approach avoids imposing normative standards of "the good life" on medical patients and allows them to decide what is in their own best interests. On the other hand, Edwards rightly highlights the intuitive and philosophical resistance to respecting patently self-destructive decisions of individuals when the person is evidently mentally ill, mood disordered, indoctrinated, or brainwashed, even if such conditions do not make the person mentally incompetent. The challenge in reconciling these two points of view is in determining a non-arbitrary way to intervene and reduce the potential for self-harm only in those cases where there is an "illegitimate influence" at work. In essence, we must non-arbitrarily define what "illegitimate" means in this context, without receding into unbridled psychiatric paternalism and while still maintaining the liberal framework of patient autonomy which is so fundamental in both law and bioethics.

The challenge is further complicated by mental illness. Eric Matthews aptly describes how we might think of the problem autonomy, or self-government, in the case where a person suffers from a mental illness which appears to impact their decision-making, but does not render them mentally incompetent. He describes that

> [t]he sufferer would be incapable of 'self-government' because he or she would either (in the most extreme case) lack a self [which is] capable of governing; or else would have a 'self' which was not his or her 'real self', in the sense described. We might express it like this: a person with this sort of disorder makes choices of a kind which he or she would not have made *but for the disorder*: he or she is not 'autonomous' or 'self-governing', but is 'governed' by the illness. If this is what the disorder consists in, then the aim of treatment of the disorder is clearly to instate (or reinstate) a 'real' self, in this non-metaphysical sense. And the justification for imposing such treatment, if necessary without the consent of the patient, would precisely be respect for autonomy, expressed as the attempt to restore autonomy to someone who presently lacks it.[274]

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[273] See Dworkin, *supra 219,* Young, *supra* note 230.

[274] Eric Matthews,"Autonomy and the Psychiatric Patient" (2000) 17:1 J of Applied Philosophy 59 at 67.

It follows that on this account, psychiatric paternalism is only justified in the case where the mental illness sought to be treated is impairing the individual's "real" self. Edwards builds on this idea in his work and articulates a method for identifying when a person is being "governed by their disorder", and therefore not exhibiting authentic autonomy. For instance Edwards might have described Scott Starson as "choosing consistently with the goals and values that are central to [his] character, [however his] character has been altered in a manner that delegitimises [his] preferences such that the resulting choices are neither reasonable nor an effective exercise of autonomy."[275]

Edwards argues that in the case of decision-making which is impacted by mental illness or other coercive influencing force, we should appeal to theories of personal identity in assessing the legitimacy of the individual's stated preference with respect to treatment in order to identify (and presumably reject) preferences that appear to arise substantially out of the coercive force and not from the individual's "self".[276]

By way of background and contrast to Edwards' theory, the Parfitian model of personal identity asserts that a single individual can change over time, but as long as she retains a persistence of psychological continuity – overlapping psychological states and memories of her previous "selves", we can speak meaningfully of her identity across these selves over time and as a single individual. To illustrate very simply, Sandra, when she is 8 years old, four feet tall, and thought Santa Claus was real, is numerically the same person as Sandra who grew up to be 38 years old, five and a half feet tall, and does not believe in Santa Claus. This is in spite of the fact that Sandra's thoughts, preferences, beliefs about the world, and personality at age 8 are markedly dissimilar from that of Sandra at age 38. Even though Sandra at 8 and Sandra at 38 may have almost nothing in common with each other, in terms of observable physical or mental traits, we identify the two states or "selves" of Sandra as being the same person because they share a psychological continuity

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[275] *Supra* note 12 at 279. I note that while Matthew's description of the problem and Edwards' theory which attempts to answer it make several claims concerning the temporality of personhood, the scope of this work does not permit an in-depth exposition and analysis of theories of personal identity, numerous, complex, and abstract as they are. I argue, however, that such an in-depth analysis should not be required in this instance, as the proposal herein concerns the recognition of long term autonomy in the context of the law on involuntary psychiatric treatment. Legislation and the common law require a degree of pragmatism and intelligibility from legal professionals and lay persons alike, therefore a detailed analysis of the finer philosophical nuances and perturbations of personal identity theory, though interesting, are not necessarily fruitful for the development of good law and policy.

[276] He also considers the situations of indoctrination, addiction, brainwashing, and being subject to severe stressors and mood disorders as being roughly equivalent.

- one grew into the other and changed gradually over time.[277] I take this account of personal identity as psychological persistence over time as a foundational starting point.

The presence of mental illnesses such as schizophrenia or dementia complicate the issue of personal identity because they can produce radical breaks or shifts in one's psychology. It is one thing for a person's beliefs and values to shift gradually over time through natural processes of maturation, education, revelation, and through the accumulation of life experience (such as Sandra's outgrowing the myth of Santa Claus), however it is a fundamentally different situation if Sandra's core beliefs change radically within a short period due to some external compulsive force (such as brainwashing or religious indoctrination) or internal compulsive force (such as mental illness). Sudden drastic changes in an individual's behaviour, beliefs, or psychological traits may or may not be precipitated by factors which we tend to count as illegitimate. For instance, there may be nothing intuitively untoward if an individual is radically "inspired" to change their core political ideology by a book they had read. Some argue that in such a circumstance, where an individual experiences such a sudden and radical shift in their beliefs and values, this break represents the limit of one "self" and the creation of another.[278] One potential moral philosophical consequence of this is that now we are dealing with two different "selves" within the same body and it becomes difficult to decide which "self" should be given priority of care or deference when there is disagreement. For instance, if psychiatric treatment could restore the prior "medicated independent self" but the current "non-medicated institutionalized self" objects to it, what should be done?

Fortunately, Edwards' thesis substantially avoids the convoluted arguments concerning personal identity and the creation of multiple selves of individuals in the case of mental illness. Rather than positing the existence of multiple selves or identities, Edwards conceives of a temporal persistence of *character* which runs parallel to the individual. As the individual grows and changes, so does her character. Her preferences can evolve slowly over time as she accumulates experience, or even quickly based on substantial revelations or life-altering events. Her character is formed and influenced by her biological and social relations, which then forms her central,

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[277] Derek Parfit,"Personal Identity" in *Tim Crane and Katalin Farkas, eds, Metaphysics: A Guide and Anthology* (Oxford, NY: Oxford University Press, 2004) 560.

[278] See eg Rebecca S Dresser, "Ulysses and the Psychiatrists: A Legal and Policy Analysis of the Voluntary Commitment Contract" (1982) 16 Harv C R C L L Rev 777. Dresser discusses the philosophical implications of the Parfitian model of personal identity in the case of mental illness and self-binding psychiatric advance directives, highlighting the argument that mental illness can function to create divergent selves.

unified self. These relations include her health-related traits, her neurobiology, attitudes, beliefs, and the like.

Considering the case where an individual, once agreeable to their own psychiatric treatment, now objects to it and is still competent to do so, the question for Edwards becomes one of assessing the legitimacy of this shift in beliefs. If the shift in preference from treatment to non-treatment arose out of a legitimate development of the individual's character (the social and biological relations forming her unified self), then the decision should be respected as it represents her authentic autonomy. If the shift in judgment results from an illegitimate source, such as indoctrination or mental illness, then her new preference for non-treatment does not arise from her authentic autonomy and psychiatric paternalism can be justified in order to restore it.

According to Edwards, the way we can judge the authenticity of an individual's current decision or preference, for instance, with respect to psychiatric treatment, is to determine whether or not she can identify with (that is, comprehend and endorse) the biological and social relations which give rise to her current post-judgment shift decision, and at the same time, identify with the relations which gave rise to her pre-judgment shift decision. If she can reasonably coherently identify with both the pre- and post-judgment preferences, this shows that the judgment shift resulted from a legitimate development of her character. If she cannot identify with both the pre- and post-judgment preferences contemporaneously, this indicates an illegitimate influence on her decision-making.[279]

For example, imagine that Sandra has schizophrenia but she is successfully treated and she lives independently, maintains a job, and has many social relationships that she enjoys. A couple of months ago she decided to lower the dosage of her medication because she was having trouble with some of the side-effects. Some symptoms of schizophrenia managed to break through during this time, which in turn caused a number of other symptoms, including some paranoid delusional thinking on her part. Due to the influence of these symptoms she stopped taking medication all together. She was unable to maintain her job due to the presence of increasingly disturbing symptoms of her illness and was eventually evicted from her apartment for non-payment of rent. Her family tracked her down and brought her to the hospital for treatment, where she was assessed as mentally competent, albeit suffering from significant symptoms of schizophrenia. She is

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[279] *Supra* note 12 at 277.

currently refusing any treatment because she believes it does more harm than good for her and because she doesn't mind living at one of the local homeless shelters.

Using Edwards' analysis, we would solicit her biographical information as well as her personal history and determine what her values and beliefs were prior to discontinuing her medication, and what they are now. We would ask Sandra to try to reconcile her prior beliefs (that treatment was good and that independent living was important to her), with her current beliefs (that treatment is bad and that living in a homeless shelter is fine). If she cannot reasonably explain the apparent lack of coherence between these two sets of her beliefs, then given the overt presence of her mental illness, some psychiatric paternalism is warranted in order to restore her to her previous medication-compliant state.

At bottom, Edwards' analysis, for all of its philosophical complexity, can be reduced to a narrative inquiry which is adjudging present decision-making on the basis of overall coherence with the individual's personal narrative over time. Significantly, the approach retains its liberal perspective as it is Sandra's own subjective preferences and conception of her own good which are being judged – not the doctor's nor society's notion of what is good for her. Assessing competence on the basis of a narrative coherence of *character* avoids the metaphysical complexities of similar arguments based on coherence of *personhood.* It is not that we are faced with deciding which "selves" of Sandra we should obey or prefer; rather, there is only one self of Sandra and we are attempting to discern the preferences which are authentically connected to it from preferences arising substantially out of the symptoms of her mental illness. Thus, Edwards has a possible answer to the inadequacy of the law in respect of assessing competence to refuse treatment as he argues that based

> [o]n the presumption that we have good reason to prefer the earlier self's goals to that of the latter, i.e. that a self constituted by healthy biological and social relations has greater moral legitimacy than one constituted by 'ill' biological and social relations, the common intuition that paternalism is warranted because a person's behaviour is vastly 'out of character' need not be overridden by our inability to demonstrate that the person is mentally incompetent.[280]

Where it concerns practical implementation as a clinical model or as statute law, assessing competent refusals psychiatric treatment need not descend into complex considerations of personal identity or persistence of character *per se*. Rather, Edwards' approach underscores the utility of a

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[280] *Ibid* at 285.

narrative analysis in identifying a more robust and authentic expression of an individual's autonomy. In essence, we should be asking whether or not the individual's preference (for no psychiatric treatment) coheres with their longstanding beliefs, values, and past decisions. If it does not, we should inquire further as to what it is that would explain the person's change of priorities or preferences. If the change cannot be reasonably explained other than as a result of a change in values or preferences motivated substantially by their mental illness, then treatment may be authorized, notwithstanding their competent objection to it.

C. Critiques of the Narrative Approach

Having simplified Edwards' theory to a narrative analysis evaluating the treatment preferences of a person suffering from a mental illness that is evidently impacting their decision-making, there are two important objections or critiques which must be considered.

First, there is the objection that a narrative analysis is not necessarily appropriate in and of itself, to assess the coherence or preferences of someone suffering from a mental illness. That is, a linear narrative is not the only way in which a story can be told, and it may be said that requiring a grand, overarching narrative of an individual is an unrealistically high standard.[281] For instance, Clive Baldwin points out that illness can cause breakdowns of communication skills which subsequently impact the ability of the ill person to construct or relay a narrative accounting of their life that is understandable to others. He cautions against assuming that this means they have lost their "self" or that they therefore have no narrative at all, as it may just be a failing of narrative

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[281] With respect to attempts to identify "authentic autonomy", Jane Heal argues that the philosophical debates on what "true" autonomy is, though philosophically interesting, may be practically unhelpful. If we want to help actualize autonomy in the mentally disordered, no (currently conceived) concept of autonomy will fit them all. There are so many kinds of mental disorder which impact our thinking and feeling in different ways that if we try to rigidly define criteria for autonomy it will not be universally applicable and therefore be likely to over or underestimate someone's autonomy in each given situation by focusing too much on the philosophical principles and not enough on the symptoms. See Jane Heal, "Mental disorder and the value(s) of 'autonomy'" in Lubomira Radoilska, ed, *Autonomy and Mental Disorder* (Oxford, NY: Oxford University Press, 2012) 3. Derek Bolton and Natalie Banner essentially agree with Heal, arguing that mentally disordered people should be thought of as behaving other than how they usually do, nor as being somehow inauthentic. They are critical of why we focus on "difference" or variation arising from psychiatric illness when we accept variations in behaviour (across people and over time) in most other contexts, and they question why many clinicians and lawmakers readily assume that autonomy is lessened or absent merely because a person experiences symptoms of a diagnosed mental illness See Derek Bolton & Natalie Banner, "Does mental disorder involve loss of personal autonomy?" in Lubomira Radoilska, ed, *Autonomy and Mental Disorder* (Oxford, NY: Oxford University Press, 2012) 77. These authors also point out the fact that centering the autonomy discussion on the presence of mental illness often diverts attention away from other sources of interference with personal autonomy, such as by oppressive health care regimes, social oppression via poverty or poor education, etc. *Ibid* at 93. For further critique of the "whole narrative" position, see also Marilyn Freidman, *Autonomy, Gender, Politics* (New York, NY: Oxford University Press, 2003).

theory that it cannot account for disjointedness caused by mental illness.[282] Baldwin recommends a countering of "master narratives"—those broad all-encompassing narratives which are sought upon diagnosis of a mental illness in order to distinguish the "real" person from the mentally ill person. In order to counter such narratives, he recommends relying on shorter narratives that "are not oriented toward coherency, authenticity and consistency, but privilege the fleeting and fragmented as contributing to the performance of identity in everyday interactions".[283]

In response to this, I argue that by and large, the acceptance of smaller narratives would not be problematic for Edwards' thesis, since Edwards expressly avoids reliance on the broad Parfitian psychological continuity conception of identity. So long as the disparate narratives were not so frequently arising and radically different, it would still be possible to track a general trend or pattern of a person's preferences and values. What matters is that there is an ability to identify with past temporal instances of the person's character, however they need not be articulated in a perfectly linear and orderly fashion.[284]

The second concern with this theory is, as with any coherence-based theory, there is the problem of bad narratives. That is, we can imagine a person who is mentally ill and has been so for a very long time. This person may have been disadvantaged, oppressed, and lacking in autonomy-enhancing relations for so long that these deficits have arguably become part of their narrative. For instance, if Sandra had always objected to her psychiatric treatment but agreed to it under duress, until one day she had enough, it would be fairly easy for her to identify, as per Edwards' theory, with both her pre and post-judgment shift decisions. Similarly, if she discontinued treatment and lived on the street for many years before her family could track her down, it is arguable that due to the passage of time, her narrative is now predominantly one of a person with a mental illness living on the street, and not one of a person living independently and complying with their treatment. With that being the case, her continued refusal of treatment is more coherent with the last few years of her life than would be an acceptance of treatment. In both of these cases, Edwards' thesis would arguably not allow for involuntary psychiatric treatment. In

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[282] *Supra* note 270 at 1023.

[283] *Supra* note 270 at 1027.

[284] In the case where an individual's preferences fluctuate wildly and frequently over time it is true that a narrative accounting of their character and values may be difficult or impossible. Yet it also seems that in such a case, the individual would likely be assessed as incompetent, therefore making the issue of psychiatric paternalism moot as they would be treated as an incompetent patient.

short, with the passage of time, the "judgment shift" can become a permanent part of the narrative, even if it was caused by overtly coercive forces.

I would argue that this admission need not be viewed as a pitfall of Edwards' narrative account. To the contrary, it seems intuitively liberal to accept the longstanding preferences of the competent individual, even if they are self-destructive. The project here was to inject a modicum of substantive content into the predominantly content-neutral understanding of autonomy in psychiatric treatment refusals, as advocated by more contemporary relational autonomy theorists.[285] Edwards' framework of evaluating illegitimate shifts in judgment functions as a modest substantive requirement to the fulfilment of an individual's autonomy. If we are to keep integrity in the liberal approach to overriding competently made treatment refusals, we cannot introduce strong subjective value judgments. As such, this may be as far as we can go, however this is not to say that we could not attempt to persuade the refusing patient. For instance, Jay Katz has suggested that it would be permissible to, on a temporary basis, impose "clinical conversation" on a patient with a view to changing their mind about their refusal, where the refusal has significant future autonomy-limiting implications.[286] Arguably, when the independence and well-being of a patient is at stake, there is at least a prima facie justification for engaging in this conversation.

D. <u>Conclusion</u>

I have identified Edwards' narrative structure as being an appropriate conceptual framework for maintaining a relatively liberal approach to involuntary psychiatric treatment, functioning to promote long-term autonomy and capacity restoration in those individuals whose present treatment refusal does not cohere with their own long-standing choices. The following final chapter of this thesis contains my analysis of the forgoing discussion of law, autonomy, and the narrative ethic as a solution to the challenge of treating marginally competent individuals who are impaired by their mental illness.

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[285] See eg Susan Dodds, *supra* note 234 at 214.

[286] Jay Katz, *The Silent World of Doctor and Patient* (Baltimore: Johns Hopkins University Press, 1984) at 141.

CHAPTER 6: The Role of the Narrative in Enhancing Autonomy in Mental Health Law

At this point, I will restate the thesis question of this work: *Under what circumstances can people who, though impacted by mental illness to some extent,* ***remain competent*** *to consent or refuse consent to medical treatment, nonetheless receive psychiatric treatment without their consent.*

A. Recounting The Problem of Involuntary Psychiatric Treatment, Canadian Mental Health Law, and The Philosophy of Autonomy

Many commentators have argued that there is a strong moral motivation for us to take some paternalistic action to aid those suffering from a mental illness which is impairing, albeit not destroying, their ability to make decisions for themselves, lest we sacrifice their well-being to an unrealistic ideal of autonomy and thereby let them "rot with their rights on".[287]

Recalling the problematization of the "chronic cycler" described in chapter two of this work, as well as the exemplar case of Scott *Starson* discussed in chapter three, the concern at the heart of this work has been with how we can justify psychiatric paternalism and override competent refusals of treatment while maintaining our moral and legal commitments to liberalism in medical treatment and ethics. This commitment is a necessity in law since the legal framework for selectively permitting involuntary psychiatric treatment of competent patients must comport with Canadian *Charter* jurisprudence and the common law, which means that it must satisfy the principle of respect for personal autonomy. The Supreme Court of Canada and numerous appellate courts have consistently emphasized and enshrined the concept of personal autonomy in section 7 guarantee of life, liberty, and security of the person,[288] and the necessity for autonomy in the particular case of consenting to mental health treatment has been specifically addressed by the Court.[289] The case law considered has revealed that the law treats autonomy predominantly as a negative right to non-interference. In particular, the cases of *Starson* and *Flemsin* demonstrate that

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[287] See Robert Solomon et al., *supra* note 128; Roger Brownsword, *supra* note 207; Gaylin & Jennings, *supra* note 206at 72.

[288] See eg *Ciarlariello v. Schacter,* [1993] 2 SCR 119; *R v Morgentaler*, [1988] 1 SCR 30; *Rodriguez v British Columbia (Attorney General),* [1993] 3 SCR 519; *AC v Manitoba (Director of Child and Family Services)*, 2009 SCC 30; *Malette v Shulman* (1990), 72 OR (2d) 417, 67 DLR (4th) 321 (Ont CA).

[289] See *Starson v Swayze*, [2003] 1 SCR 722; *Fleming v Reid* (1991), 4 OR (3d) 74.

the law does not accept the promise or potential of long term autonomy (in the form of independent living or freedom from institutionalization) as being a counter balancing justification for even a brief short term intrusion (in the form of compulsory treatment). Further, despite the uniform applicability of the *Charter*, Canadian jurisdictions take a divided approach to involuntary treatment of mental illness.

Ontario, Quebec, Manitoba, the Northwest Territories, and Nunavut will involuntarily admit patients on the basis that it is necessary for their own protection, however if the patient is assessed as mentally competent to consent to treatment and refuses it, then treatment cannot be ordered. The result of this may be that the patient will be confined to an institution, such as the case in *Starson*, because they are assessed as being a danger to themselves or others, but shall remain untreated for months or years until they either relent and consent, or deteriorate into mental incompetency. This is what has been referred to as the "warehousing" of the mentally ill and arguably damages their long term liberty and health.[290]

Alberta, Prince Edward Island, New Brunswick, and the Yukon Territory purport to follow a similar approach, however each of their respective legislation contains provisions which permit the overruling of objections to treatment made by mentally competent patients based on a "best interests" standard. Therefore, while there is initial deference to individual autonomy, psychiatric paternalism can eventually prevail, which may work to enhance the long term autonomy of the individual.[291]

British Columbia essentially combines the processes and criteria for involuntary admission and involuntary treatment thereby avoiding the "warehousing" of patients with a mental disorder; however, this comes at a cost of potentially overruling competent patients' medical autonomy on the basis that they are considered dangerous.[292]

Saskatchewan, Nova Scotia, and Newfoundland take the inverted approach to both involuntary admission and treatment, wherein if a person assessed as competent to consent to treatment but refuses to undertake it, then the person cannot be involuntarily admitted or treated.

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[290] *Mental Health Act*, R.S.O. 1990, c. M.7; *Health Care Consent Act, 1996* SO 1996, c2; *Civil Code of Québec*, SQ 1991, c 64 [CCQ]; *An Act respecting the Protection of Persons Whose Mental State Presents Danger to Themselves or to Others*, RSQ, c P-38.001; *The Mental Health Act,* CCSM c M110, ss 8, 26, 27(2), 28.

[291] *Mental Health Act*, RSA 2000, c M-13, ss 26, 27; *Mental Health Act*, RSPEI 1988, c M-6.1; *Mental Health Act*, RSNB 1973, c M-10; *Mental Health* Act, RSY 2002, c 150.

[292] *Health Care (Consent) and Care Facility (Admission) Act,* 1996 RSBC c 181, ss 3-5, 14-18; *Mental Health Act*, RSBC 1996 c288, ss 31, 22.

This also avoids the warehousing of patients without treating them, however in this case the patient's short term autonomy is granted at the cost of their mental and physical health, as they may be dangerous to themselves or others and may deteriorate without treatment.[293]

The existence of these regimes under the same *Charter* is puzzling, given the radically different patient outcomes which each regime creates. On one extreme end, British Columbia lags the furthest behind on the "pendulum swing" of psychiatry towards the emphasis on liberal autonomy, essentially erasing any presumption or inquiry into the capacity for autonomous decision-making of the patient once they are diagnosed with a mental illness and deemed to be in need of treatment. On the other end of the spectrum, jurisdictions such as Ontario place great protections on competent patient's rights to bodily integrity however with the unfortunate result of "warehousing" those patients who are dangerous, despite being mentally competent. Whether the patient is "warehoused" in an institution or else permitted to live free however still remaining at the mercy of their illness, and therefore more likely to be homeless and unable to maintain employment, the patient's options in life are substantially reduced and their capacity for meaningful autonomy dwindles all the same. This approach, I have argued, sacrifices the long term autonomy prospects of the patient, including their ability to live independently, unencumbered by their illness, in order to satisfy their short term autonomy, insofar as involuntary treatment would have consisted in an unwanted invasion of the body with chemical substances.

The evolution of the bioethical concept of autonomy has been substantial. What began with Millian autonomy as an emphasis on liberty and mere freedom from constraint became more nuanced as philosophers such as Dworkin, Frankfurt, and Friedman developed criteria for defining a more authentic and robust concept of autonomy. It was not enough that a person be unconstrained from acting for their actions to be considered meaningfully autonomous; the desires and preferences of the individual had to bear the right relation to the purportedly autonomous actions. From this understanding, we can see how a smoker who chooses to smoke because he is addicted and in spite of his overarching desire to quit smoking, lacks a certain degree of autonomy even though he evidently makes a choice to smoke a cigarette.

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[293] *Mental Health Services Act*, SS 1984-85-86, c M-13.1, s 24(2)(a); *Health Care Directives and Substitute Health Care Decision Makers Act,* SS 1997-2000-04 c H-0.001, s 2(1); *Mental Health Care and Treatment Act,* SNL 2006, cM-9 1, s 17(b).

Subsequently, within the bioethical discourse, Beauchamp and Childress's principlism remained the dominant paradigm in medical ethics and included autonomy as one of its core components. This understanding of autonomy, though it continued to evolve, has been repeatedly critiqued for having been too individualistic in nature. In particular, the feminist critique of autonomy has pointed out the presumption of rational self-interest and a very high degree of independence and capacity for detached and confident self-government, much of which may be lacking in those who are marginalized or otherwise experiencing oppressive circumstances.[294]

In the course of the feminist critique, scholars such as Friedman, Dodds, and Stoljar have highlighted the fundamental differences between content-neutral (procedural) versus content-laden (substantive) theories of autonomy.[295] The former and eminently liberal ideal of understanding autonomy locates the inquiry in determining whether or not the individual has access to sufficient information, as well as the cognitive and communication capacities to make and express a decision based on their own values. No judgment is made as to what their values are, no matter how self-destructive they might be. In contrast, a substantive concept of autonomy would insert some material requirement into the content of the purportedly autonomous decision. Although this may import a degree of judgment as to the factors motivating the choice which in itself seems illiberal and reminiscent of the paternalistic "doctors know what is best for you" mentality, this approach also allows us to acknowledge and address substantive impediments to the individual's choice-making ability, such as the reality that they are oppressed, indoctrinated, or otherwise impaired.

Finally, Jennifer Nedelsky and Susan Sherwin provide valuable accounts of relational autonomy which underscores the ways in which law and policy can be constructed to either enhance or limit the capacities for individuals to develop independence and autonomy, and firmly demonstrate the inadequacy of relying on a purely negative "protection" conception of autonomy.[296]

With respect to the development of the concept of autonomy in Canadian *Charter* jurisprudence, I argue that as a result of the law's amenability to legislating in the negative sense (telling us what is *not* permitted as opposed to telling us what *is* permitted), the result of Canadian

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[294] See GM Stirrat and R Gill, *supra* note 227.

[295] See Marilyn Freidman, *supra* note 229 at 19; Susan Dodds, *supra* note 234 at 214; Natalie Stoljar, *supra* note 233 at 95.

[296] Jennifer Nedelsky, *supra* note 239; Susan Sherwin, *supra* note 244 at 83.

courts' interpretations of the principle of autonomy in the context of medical patients receiving treatment, has been to equate autonomy with the principle of informed consent. I agree with Brownsword and Archard that a ritualization of informed consent can lead to a "cult of consent", insofar as informed consent becomes a *pro forma* matter, reduced to a procedural step which is mainly invoked to guard against potential liability.[297] Most of the mental health regimes across Canada, as well as the psychiatric criteria within the MacCAT-T mental capacity assessment, essentially require that a patient be able to understand, appreciate, and then communicate the nature and consequences of accepting or refusing treatment. Thus, provided with the requisite information about the proposed treatment, and provided the patient can pass this test of competency, respecting their "autonomy" consists in abiding by their expressed decision. This assessment is purely procedural and content neutral, and therefore mandates against any significant inquiry into the legitimacy of the factors which may be impacting the patient's decision, and therefore may not help to promote the capacity for the individual's autonomy.

This account of autonomy is deficient. As Sherwin opined, "[i]ndividualistic interpretations of autonomy seem to suggest that medical consumers should be provided with whatever services are voluntarily chosen…but a relational understanding of autonomy requires that we raise questions about the context of those choices".[298] Moreover, I argue that we should follow the reasoning of Nedelsky and make our project to go beyond merely "building walls of negative individual protections"; we ought to make law and policy which recognizes the reality of the impairment of mental illness, even when it is not total, in order to ensure the patient's decision-making capacities and future autonomy are enhanced.[299]

B. The Modest Proposal

With ample justification for engaging in a degree of psychiatric paternalism in order to advance the patient's long term autonomy, I have argued that Craig Edward's narrative thesis provides a non-arbitrary way of distinguishing cases where paternalistic intervention is warranted from those where it is not.[300]

Edwards' approach permits the introduction of a substantive component to the assessment of the patient's autonomy – the requirement for narrative coherence between their treatment

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[297] See Roger Brownsword, *supra* note 207; David Archard, *supra* note 210 at 114-118.
[298] Susan Sherwin, *supra* note 244 83.
[299] Jennifer Nedelsky, *supra* note 243
[300] See Craig Edwards, *supra* note 12 at 279.

decision and their past preferences, values, and decisions. This theory retains the liberalness endorsed by the contemporary anti-paternalistic bioethical discourse because it does not insert any substantive benchmark or requirement for compliance with anyone else's standards or values; the question is whether or not the individual's *own* choice coheres with their *own* narrative. If so, then the choice is rightly viewed as meaningfully autonomous and should be respected; if not, then some paternalistic intervention may be warranted in order to restore the capacity for autonomy to the individual, as evinced by their own past practices and values. Likewise, since the project is aimed at preserving or restoring individual autonomy, there is little *prima facie* reason to think that the *Charter*'s requirement for respect for autonomy would be transgressed by a law which has this aim.

Canadian statute law concerning involuntary psychiatric treatment is currently divergent. In order to give effect to the principles discussed herein, and in particular, to the narrative account of autonomy, the law should ideally be homogenized. The following is an example of a substantive change which could be added in order to provide a useful narrative analysis.

C. The Modest Proposed Legislative Change

This example employs the criteria of section 29(1)(3)(a) and (b)(i)-(iv) of the *Alberta Mental Health Act*,[301] which must be considered by the Mental Health Review Board when it is considering whether or not to grant an order overriding a competent patient's refusal of psychiatric treatment on the grounds that it is in their best interests to do so.

> Before making an order permitting psychiatric treatment of a competent patient who has refused such treatment, the Board shall consider whether:
> (a) the attending physician has examined the formal patient,
> (b) the proposed treatment is in the best interest of the formal patient having regard to the following:
> (i) whether the mental condition of the patient will be or is likely to be improved by the treatment; (ii) whether the patient's condition will deteriorate or is likely to deteriorate without the treatment; (iii) whether the anticipated benefit from the treatment outweighs the risk of harm to the patient; (iv) whether the treatment is the least restrictive and least intrusive treatment that meets the requirements of subclauses (i), (ii) and (iii); and

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[301] *Mental Health Act*, RSA 2000, c M-13, *supra* note 153 at s 29(3).

(v) whether, in the opinion of the attending psychiatrist, the patient's mental illness has reasonably caused a negative change in the patient's longstanding attitudes, values, and preferences, and the refusal of treatment appears to be substantially motivated by the same attitudes, values, or preferences.

This example represents only one way in which the law could be framed. It is constructed so as to give a legal undergirding to Edwards' thesis, however it is understood that a substantial body of policy with respect to implementation by the medical professionals and the use of narrative analyses would be required. The Alberta legislation, and other similar sets of legislation which permit an override of competent treatment refusals if it is in the best interest of the patient. [302] This legislation was chosen amidst the myriad of approaches in Canada as a foundation for my proposal for several reasons. First, this approach represents a middle ground between "warehousing" competent but dangerous patients, and engaging in overt psychiatric paternalism by treating competent patients against their objections. Second, competent patients are afforded some procedural safeguards to unauthorized treatment. For instance, their doctor must apply to the Review Board for approval of involuntary medication, which in turn must conduct its own assessment of the patient's best interests. By bolstering the considerations undertaken in this review with the consideration of the narrative coherence of the patient's preferences, the Review Board must formally consider whether or not the patient's preferences are emanating substantially from their symptoms. This permits a measure of discretion in authorizing involuntary treatment in cases such as Scott Starson, or the aforementioned "chronic cycler", yet retains a reasonable amount of procedural safeguards in that it is not left to the healthcare staff to override treatment refusals on their own. Under this framework, physicians would still apply to the Review Board but would be able to engage in a more realistic dialogue of the patient's capacities and motivations, and need not be restricted to the narrow competency analysis, which may otherwise consist in as little as "can they understand and appreciate the nature and consequences of the treatment".

D. Conclusion

My aim in this work has been to reconcile the analyses of Canadian mental health legislation and *Charter* jurisprudence, with the generally more developed and nuanced concepts of autonomy in the bioethical discourse, in order to assess the underlying ideological goals and methods of the law. What is apparent from cases such as *Starson* is that the legal protections

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[302] Including the mental health legislation from Prince Edward Island, New Brunswick, and Nova Scotia.

afforded to personal autonomy in the medical context are primarily oriented to guard against intrusions as opposed to empowering or enhancing capacities for independence and self-government. While the contemporary and relational accounts of autonomy demonstrate the utility of taking a more proactive approach to enhancing individual autonomy, the law appears less willing or able to evolve in kind, for fear of regressing towards an ethic of undue illiberal psychiatric paternalism.

I have argued that a narrative approach can provide an adequate principled middle ground between regressive paternalism and the kind of liberalism which makes us reluctant to help those who appear to be in need. Certainly more development of this argument is needed, however it is safe to say that if we wish to take seriously a more nuanced and constructive positivistic understanding of autonomy in those living with a mental illness, it is not sufficient to maintain a system of law and policy which ascribes unrealistic levels of autonomy and declines to assist those in need. The better approach is to determine how to enhance the individual's capacity for autonomy based on a realistic assessment of their history, values, and preferences.

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