

TREATMENT DELAYED - LIBERTY DENIED

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Starson v. Swayze, and the Ontario law upon which it is based was hailed as a victory for psychiatric patients. However, by 2005, Starson had been involuntarily detained without treatment for nearly seven years and his deteriorating mental health had brought him close to death. While Starson's psychiatrists wanted to treat him, the law prevented them from doing so. This paper analyzes the laws that ensnared Starson and others and proposes amendments to better protect seriously ill patients. We will demonstrate that in attempting to safeguard autonomy, the Ontario law imperils and physical and mental health of involuntary psychiatric patients, and often results in subjecting them to prolonged detention, mental anguish, physical and chemical restraint, and solitary confinement. A better balance needs to be struck among the competing interests of these patients. In striking this balance, consideration must be given to the law's real-world impact on the lives and liberty of those it purports to protect.

L'arrêt Starson c. Swayze, de même que le droit ontarien sur lequel il se fonde, a été acclamé comme une victoire pour les patients psychiatriques. Pourtant en 2005, M. Starson était en placement non volontaire depuis presque sept ans, sans traitement; sa santé mentale s'étant détériorée au point où il était à l'article de la mort. Ses psychiatres voulaient le traiter, mais la loi les en empêchait. Le présent article analyse les lois qui ont pris au piège M. Starson et d'autres et propose des modifications afin de mieux protéger les patients gravement malades. Nous démontrerons qu'en tentant de protéger l'autonomie, le droit ontarien met en péril la santé physique et mentale des patients en cure obligatoire et fait souvent en sorte qu'ils soient soumis à un placement prolongé, à une angoisse mentale, à des contraintes physiques ou chimiques et à un placement en isolement. Il convient de mieux concilier les intérêts divers de ces patients. Pour ce faire, il faut tenir compte de l'incidence réelle de la loi sur la vie et la liberté des personnes qu'elle entend protéger.

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1. Introduction

By May 2005, Scott Jeffery Starson, or Professor Starson as he insisted on being called, had been continuously held against his will in Ontario psychiatric hospitals for nearly seven years without treatment. Starson's psychiatrists unanimously believed that he was not capable of giving or refusing consent and wanted to treat him with the standard medications for his illness. The Ontario law, however, prevented them from doing so. Once Starson challenged his psychiatrists' 1998 finding that he was not capable, no treatment could be initiated without his consent until the courts finally resolved this capacity issue.

In 2003, a majority of the Supreme Court of Canada upheld Starson's position that he had been capable to refuse the proposed treatment in 1998.¹ The media and members of the legal community viewed the result as a victory for Starson and, more generally, for the rights of involuntarily detained psychiatric patients.² But does the decision and the legislation underlying it really constitute a victory for Starson and other psychiatric patients?³

As his psychiatrists had predicted, Starson's mental health deteriorated without treatment, particularly after 2003. Starson developed paranoid delusions that if he ate or drank too much his imaginary son would be tortured. Starson's weight fell to 118 pounds and he became dehydrated to the point that he was at risk of imminent kidney failure. Fearing that Starson might die, his psychiatrist again assessed him to be incapable of consenting to treatment.⁴ In the spring of 2005, the Ontario Consent and Capacity Board (CCB) confirmed

¹ *Starson v. Swayze*, [2003] 1 S.C.R. 722 [*Starson*].

² See e.g. "The Court is Right to Uphold Autonomy of Capable Patients," Editorial, *The Vancouver Sun* (10 June 2003) A12; E. Fitzpatrick, "Lessons From *Starson* on Consent & Capacity" (2006) 26(4) *Health Law in Canada* 74; and Anita Szigeti, "The Big Cases that Changed the Landscape" in *Honouring the Past, Shaping the Future: 25 Years of Progress in Mental Health Advocacy and Rights Protection* (Toronto: Queen's Printer for Ontario, 2008) at 202.

³ Starson's mother, his substitute decision-maker, was devastated by the Supreme Court decision, which she viewed as a life sentence. She is quoted as saying, "I don't think it's a very humane judgment. It's a disaster ... they have destroyed his life and his dreams;" see Tracey Tyler, "Bright Mind, No Bright Future" *Toronto Star* (7 June 2003) A4.

⁴ (*Re*) *Schutzman*, [2005] O.R.B.D. No. 1841 at paras. 18 and 19 [*Schutzman* 2005]. In 1993, Scott Jeffery Schutzman legally changed his last name to Starson. Nevertheless, some of the Criminal Review Boards continued to use his birth name, Schutzman.

that Starson was not capable and his substitute decision-maker consented on his behalf. Contrary to Starson's wishes, he was administered the antipsychotic medications that had been originally proposed.

Starson's delusions lessened, his thinking became more focused, and he began to eat, regain weight, interact with the staff, and groom himself.⁵ By August 2005, Starson's mental and physical health had improved dramatically.⁶ In the end, Starson was treated with the medications that he had fought to avoid, but in the interim he had lost seven years of liberty and almost lost his life. What happened to Starson could not have occurred in any other province⁷ or apparently in most other democratic Commonwealth jurisdictions.⁸

The purpose of this paper is to analyze the laws that ensnared Starson and propose amendments which would better protect seriously ill psychiatric patients. We will demonstrate that rather than promoting the rights of involuntary psychiatric patients, the Ontario law results in many patients being subject to prolonged periods of detention, physical and chemical restraint, and solitary confinement. In Section 2 of the paper, we outline the complex and evolving provincial mental health legislation and *Criminal Code*⁹ provisions governing involuntary psychiatric patients and analyze in depth the relevant sections of the Ontario *Health Care Consent Act, 1996 (HCCA)*.¹⁰

⁵ *Ibid.* at paras. 20 and 21.

⁶ *(Re) Schutzman*, [2006] O.R.B.D. No. 2024 at para. 14 [*Schutzman* 2006].

⁷ A result similar to that in *Starson* could occur pursuant to the Northwest Territories *Mental Health Act*, R.S.N.W.T. 1988, c. M-10, ss. 19.1 and 26.1(3). Nunavut has adopted the laws of the Northwest Territories and consequently the situation in these territories would be identical; see *Nunavut Act*, S.C. 1993, c. 28, s. 29. For a comparison of the mental health legislation across Canada, see John Gray and Richard O'Reilly, "Clinically Significant Differences Among Canadian Mental Health Acts" (2001) 46(4) *Can. J. Psychiatry* 315; and more generally, John E. Gray, Margaret A. Shone and Peter F. Liddle, *Canadian Mental Health Law and Policy*, 2d ed. (Markham: LexisNexis Canada Inc., 2008) at 197-223.

⁸ See for example, *Mental Health Act 1983* (U.K.), 1983, c. 20, s. 58(3); *Mental Health (Care and Treatment)(Scotland) Act 2003*, A.S.P. 2003, c. 13, ss. 57 and 64(5); *The Mental Health (Northern Ireland) Order 1986*, S.I. 1986/595 (N.I. 4), s. 64(3); *Mental Health (Compulsory Assessment and Treatment) Act 1992* (N.Z.), 1992/46, s. 30; and *Mental Health Act 2007*, (N.S.W.), ss. 84 and 101 (which is comparable to the law in most other Australian states).

⁹ R.S.C. 1985, c. C-46.

¹⁰ S.O. 1996, c. 2, Sch. A.

Section 3 begins with a summary of the number and outcomes of challenges by Ontario psychiatric patients to findings that they were incapable of making treatment decisions. This is followed by a detailed discussion of the small number of case histories, including Starson's, in which the courts either overturned a finding of incapacity or addressed a related issue. These cases are put in the broader context of the patient's prior and subsequent psychiatric history. While the *Canadian Charter of Rights and Freedoms*¹¹ is referred to if it arose in one of the case histories, it is not feasible to provide a broader *Charter* analysis of the underlying legislation in this paper.¹²

Section 4 summarizes the implications of the preceding review. The paper ends with proposals to bring Ontario law into line with that of most other jurisdictions. Most importantly, the proposals would protect psychiatric patients from languishing untreated in hospital with little prospect of becoming well enough to regain their liberty.

2. Consent to Psychiatric Treatment and Capacity in Ontario

*Mental Health Act (MHA)*¹³

The *MHA* governs, among other things, the admission of voluntary and involuntary patients to psychiatric facilities,¹⁴ the terms of community treatment orders,¹⁵ and the use of chemical and other restraints.¹⁶ The *MHA* previously governed consent and capacity to consent to psychiatric treatment and the "review boards" that resolved patient challenges regarding these issues. However, these

¹¹ Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [*Charter*].

¹² For a discussion of some of these issues, see Peter Carver, "Mental Health Law in Canada" in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds., *Canadian Health Law and Policy*, 3rd ed. (Markham, Ontario: LexisNexis, 2007) 399 at 415-19; and Ronald Sklar, "Starson v. Swayze: The Supreme Court Speaks Out (Not all that Clearly) on the Question of 'Capacity'" (2007) 52(6) *Can. J. Psychiatry* 390 at 394-95. Both authors suggest that legislation which does not give priority to the prior capable wish of a currently incapable psychiatric patient would be vulnerable to a challenge under section 7 of the *Charter*; but see *Deacon v. Canada (Attorney General)*, [2006] F.C.J. 1153 at para. 73 (Fed. C.A.).

¹³ R.S.O. 1990, c. M.7.

¹⁴ *Ibid.*, ss. 12, 13, 19, and 20.

¹⁵ *Ibid.*, ss. 33.1-33.9.

¹⁶ The *MHA* authorizes the use of restraints, when necessary, in dealing with patients involuntarily detained for assessment, under a certificate of involuntary admission or pursuant to the *Criminal Code*; see *ibid.*, ss. 15(5)(b), 20(4) and 25. Section 53 of the *MHA* requires that any use of restraint be clearly documented.

matters were transferred¹⁷ to the *Consent to Treatment Act, 1992 (CTA)*¹⁸ which, in turn, was repealed and replaced by the *HCCA*.¹⁹ Thus, the *MHA* currently regulates voluntary and involuntary admission and detention of psychiatric patients, but not their consent to treatment or capacity.

B) Health Care Consent Act, 1996

The *HCCA* governs consent to treatment for patients admitted voluntarily or involuntarily under the *MHA*, and those involuntarily detained under the *Criminal Code* following a finding of unfitness to stand trial or a finding that a person is not criminally responsible (NCR) on account of mental disorder.²⁰ The *HCCA* provides that regulated health practitioners cannot initiate treatment unless they are of the opinion that the patient is competent and has consented, or they are of the opinion that the patient is incompetent and the patient's substitute decision-maker has consented in compliance with the Act.²¹

The *HCCA* defines capacity broadly in terms of a person's ability to understand information about a proposed treatment and appreciate the reasonably foreseeable consequences of consenting or refusing consent.²² The test of capacity does not address whether the patient is able to make or has made a prudent or rational decision. The *HCCA* states that individuals are presumed to be capable and that the presumption may be relied upon unless there are reasonable grounds to believe otherwise.²³ The courts have held that this presumption requires health care practitioners to establish, on a balance of probabilities, that a patient is incapable.²⁴

¹⁷ *Consent and Capacity Statute Law Amendment Act, 1992*, S.O. 1992, c. 32, s. 20(1) [*Consent and Capacity Amendment Act*].

¹⁸ Virtually all of the *Consent to Treatment Act (CTA)*, S.O. 1992, c. 31 was proclaimed in force on April 3, 1995.

¹⁹ The *HCCA*, *supra* note 10, came into force on March 29, 1996.

²⁰ *Criminal Code*, *supra* note 9, s. 672.38.

²¹ *HCCA*, *supra* note 10, s. 10(1)(a).

²² *Ibid.*, s. 4(1).

²³ *Ibid.*, s. 4(2) and (3).

²⁴ See e.g. *Re Koch* (1997), 33 O.R. (3d) 485 at 521 (Gen. Div.); and *Starson*, *supra* note 1 at 760.

The *HCCA* also requires health practitioners to obtain an informed consent to treatment. In order for a consent to be "informed," the patient's questions must be answered, and he or she must be provided with information on the nature, expected benefits, material risks, and material side effects of the proposed treatment. Information must also be provided on the alternatives to, and the likely consequences of forgoing, the proposed treatment; see *HCCA*, *supra* note 10, s. 11(1)2, (2) and (3).

The Act authorizes specified categories of individuals to make decisions on an incapable patient's behalf and sets out the criteria for making these decisions.²⁵ It is only after a patient has been found to be incapable that legal authority to make decisions for the patient vests in his or her substitute decision-maker.²⁶ The *Substitute Decisions Act, 1992 (SDA)*²⁷ permits those who are sixteen years old or older, and capable, to formally designate someone to serve as their substitute decision-maker for treatment if they become incapable. In the absence of a prior designation, the hierarchy of substitute decision-makers set out in the *HCCA* applies.²⁸ The hierarchy ranges from a court-appointed guardian of the person to the Public Guardian and Trustee if no other person in the hierarchy is available.²⁹

Two features of the current law create the potential for prolonged indeterminate detention of psychiatric patients without treatment: delays pending final court resolution of patient capacity; and the enduring impact of prior expressed wishes.

a) Delays Pending Court Resolution of Patient Capacity

A patient admitted to a psychiatric facility who has been found to be incapable with respect to proposed treatment for his or her mental disorder must be given written notice of this finding. The patient's attending physician must also ensure that the facility's rights adviser is promptly notified of the finding.³⁰ In turn, the rights adviser must promptly meet with the patient to explain the significance of the finding and to inform the patient of his or her right to seek a review of the incapacity finding from the CCB.³¹ At a patient's request, the rights

²⁵ *Ibid.*, ss. 20-21. The principles governing the various categories of substitute decision-makers are set out in the *Substitute Decisions Act, 1992*, S.O. 1992, c. 30 (*SDA*).

²⁶ *HCCA*, *supra* note 10, s. 10(1)(b). The Act includes a limited exception to the consent requirement when "emergency treatment" is required; see *ibid.*, ss. 25-27.

²⁷ *SDA*, *supra* note 25, ss. 46-50.

²⁸ *HCCA*, *supra* note 10, s. 20(1) and (3).

²⁹ *Ibid.*, s. 20(1)1 and (5).

³⁰ *Mental Health Act Regulations*, R.R.O. 1990, Reg. 741, s. 15(1). This provision only applies to patients who are fourteen years of age or older, and is subject to some other limited exceptions. Patients who are found to be incapable with regard to other treatment or who are not in a psychiatric facility must also be informed of the significance of a finding of treatment incapacity; see *HCCA*, *supra* note 10, s. 17. However, this obligation is far less onerous than that imposed in regard to incapacity to make treatment decisions for a mental disorder.

³¹ Reg. 741, *ibid.*, s. 15(2). Again, there are some limited exceptions to this requirement; see *ibid.*, s. 15(3), (5) and (6).

adviser must assist him or her in applying to the CCB for a review and in obtaining legal assistance.³²

Except in an emergency, no treatment can be initiated if a patient indicates that he or she intends to apply or has applied to the CCB for a review of the finding of incapacity.³³ Unless the parties agree to a postponement, the CCB must meet to hear the application within seven days and provide a copy of its decision to the parties the following day.³⁴ Even if the Board upholds the practitioner's finding of incapacity, treatment cannot be initiated if the patient appeals the Board's decision to the courts.³⁵ The process of appealing through the courts is particularly time-consuming. For example, had the Supreme Court of Canada agreed with the psychiatrists and the CCB that Starson had been incapable in 1998, he still would have been hospitalized without treatment for five years. Even in this circumstance, Starson's psychiatrists would not have had any authority to initiate treatment. Rather, the psychiatrists would have had to assess Starson's capacity as of 2003. A Supreme Court finding that Starson had been incapable in 1998 would not have meant that he was incapable five years later. As indicated, the *HCCA* presumes that patients are capable, and Starson's psychiatrists would again have had the burden of proving otherwise.³⁶

b) The Enduring Impact of Prior Expressed Wishes

The *HCCA* provisions on prior expressed wishes can pose additional barriers to treating incapable psychiatric patients. Individuals may, while capable, express wishes governing their future treatment if they become incapable. The wish can be expressed in a power of attorney, any other written form, orally, or in any other manner.³⁷ The wish need not be based on an informed, considered or even rational view of its treatment or legal significance. Nevertheless, those exercising substitute consent must do so in accordance with any known "wish applicable to the circumstances that the incapable person expressed

³² *Ibid.*, s. 15(4).

³³ *HCCA*, *supra* note 10, s. 18(1) and (4). The Act defines the term "emergency" narrowly; see *ibid.*, s. 25(1). Similarly, no treatment can be initiated if a patient intends to apply or has applied to appoint a personal representative to make treatment decisions on his or her behalf; see *ibid.*, s. 18(2).

³⁴ *Ibid.*, s. 75(2) and (3).

³⁵ *Ibid.*, s. 18(3)(d). However, the court to which the appeal is taken does have a narrowly defined power to order treatment prior to the final disposition of the case; see *ibid.*, s. 19(1).

³⁶ *Ibid.*, s. 4(2). Indeed, the Act states that a person may be capable with respect to a treatment at one time and incapable at another; see *ibid.*, s. 15(2).

³⁷ *Ibid.*, s. 5(1) and (2).

while capable and after attaining 16 years of age.”³⁸ If no such wishes are known to the substitute decision-maker, only then can he or she make treatment decisions based on the incapable patient’s “best interests.”³⁹

Consequently, if an incapable patient had expressed a wish, while capable, to refuse psychiatric medication, the patient’s substitute decision-maker could not consent even if he or she was convinced that the medication was essential to the patient’s recovery. Nor does it matter that the substitute decision-maker views the wish as having been made rashly. Moreover, if an incapable patient had previously refused a treatment and there was no successful challenge to his or her capacity at that time, this prior refusal would most likely be viewed as a prior capable wish to forgo the treatment. That wish is binding on the patient’s substitute decision-maker, regardless of the fact that it might result in the patient’s prolonged hospitalization without treatment.

C) The Criminal Code and Consent to Psychiatric Treatment

Four of the six patients discussed in Section 3 of the paper were detained in psychiatric facilities under the *Criminal Code* after they committed an offence.⁴⁰ Consequently, it is necessary to briefly outline the relationship between the *Criminal Code* and *HCCA*. However, just as the consent principles have changed over the study period, so too have the *Criminal Code*’s mental illness provisions. Prior to 1992⁴¹ an accused who was found not guilty by reason of insanity under section 16 of the *Criminal Code* was typically detained in a psychiatric facility under a Lieutenant Governor’s warrant. In 1992, “sweeping changes”⁴² were made to the *Criminal Code*.⁴³ Although the test in section 16

³⁸ *Ibid.*, s. 21(1)1.

³⁹ *Ibid.*, s. 21(1)2. Moreover, substitute decision-makers must “take into consideration” a range of factors in determining what is in the incapable person’s best interests. In addition to the likely risks and benefits of the proposed treatment, the substitute decision-maker must consider the incapable person’s known values and beliefs, and any wishes he or she had expressed while incapable or under the age of sixteen; see *ibid.*, s. 21(2).

⁴⁰ One of the two remaining patients had committed a criminal offence, but was involuntarily detained under the *MHA* when the criminal charges were dropped.

⁴¹ Initially, the Canadian law reflected the British approach to the insanity defence in *R. v. M’Naghten* (1843), 8 E.R. 718 (H.L.).

⁴² This is how the Supreme Court of Canada characterized the amendments in *Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] 2 S.C.R. 625 at 646.

⁴³ *An Act to amend the Criminal Code (mental disorder) and to amend the National Defence Act and the Young Offenders Act in consequence thereof*, S.C. 1991, c. 43.

remained largely the same,⁴⁴ a special verdict of “not criminally responsible on account of mental disorder” (NCR)⁴⁵ replaced the finding of not guilty by reason of insanity. Quasi-judicial provincial review boards were created and given broad statutory responsibility for supervising individuals who had been found to be unfit to stand trial or NCR.⁴⁶ These boards will be referred to as “criminal review boards” in order to distinguish them from the “review boards” that addressed capacity, treatment and detention issues under the Ontario *MHA*.

Currently, a court may order an accused to be detained and subjected to a comprehensive psychiatric assessment if there is reason to believe that he or she is unfit to stand trial or was mentally ill at the time of the offence.⁴⁷ If the accused is found unfit to stand trial, the court may order him or her to be detained and treated without consent for up to sixty days.⁴⁸ If the accused’s condition remains unchanged, the criminal trial will be stayed. However, if the accused’s condition improves and he or she becomes fit to stand trial, the criminal proceedings will continue as if the fitness issue had never arisen.⁴⁹

If the accused is held to be NCR, the court is required to make one of three dispositions – an absolute discharge, a conditional discharge or detention in a hospital. The court must make the least onerous and least restrictive disposition, taking into consideration the need to protect the public from dangerous people, the accused’s mental condition, and his or her reintegration into society and other needs.⁵⁰ An absolute discharge must be ordered if the individual does not pose a significant

⁴⁴ Currently, the section provides that no person is criminally responsible for an act committed while suffering from a mental disorder that rendered him or her “incapable of appreciating the nature and quality of the act ... or of knowing that it was wrong.”

⁴⁵ *Criminal Code*, *supra* note 9, s. 672.34.

⁴⁶ *Ibid.*, s. 672.38(1). The Canadian courts have referred to individuals who have been found to be NCR as mentally disordered accused; see e.g. *R. v. Owen*, [2003] 1 S.C.R. 779. In our view, the term “mentally disordered accused” is problematic. These individuals are no longer accused. Moreover, they were mentally disordered at the time the criminal act occurred and were not necessarily mentally disordered at or after the time they stood trial.

⁴⁷ *Ibid.*, s. 672.11. An accused will be found unfit to stand trial if he or she is unable, because of a mental disorder, to understand the nature or object of the proceedings, understand its possible consequences, or communicate with counsel; see *ibid.*, s. 2 definition of “unfit to stand trial.”

⁴⁸ *Ibid.*, s. 672.58.

⁴⁹ *Ibid.*, s. 672.28.

⁵⁰ *Ibid.*, s. 672.54.

threat to public safety.⁵¹ Criminal review boards are authorized to make dispositions if the court fails to do so.⁵²

Moreover, no disposition can include a psychiatric or other treatment order unless the individual or their substitute decision-maker has consented, and the court or criminal review board considers the treatment to be “reasonable and necessary in the interests of the accused.”⁵³ Consequently, neither the courts nor the criminal review board have authority to impose treatment on an accused who has been found to be NCR, even if that treatment is obviously in the accused’s best interests. Nor is it relevant that the lack of treatment will relegate the patient to languishing in hospital with little prospect of becoming well enough to be released. This stands in sharp contrast to section 672.58 of the *Criminal Code* which authorizes the forced treatment of accused without their consent if they have been found unfit to stand trial.

The criminal review boards maintain authority over an individual who has been found to be NCR or unfit to stand trial until he or she has been absolutely discharged.⁵⁴ While the boards cannot impose treatment, they determine where and under what conditions these individuals are detained, and the scope of their privileges whether they live in a psychiatric facility or in the community.⁵⁵ A criminal review board must assess each of these individuals at least once a year to determine if he or she continues to pose a significant threat to public safety.⁵⁶ Individuals who no longer pose a threat must be discharged absolutely, even if they exhibit serious symptoms of untreated mental illness.⁵⁷

3. A Review of Judicial Involvement in Treatment Incapacity Cases

A) Background

Psychiatric patients are granted broad procedural, evidentiary and legal protections in the capacity assessment process. While it is not

⁵¹ *Ibid.*, s. 672.54(a).

⁵² *Ibid.*, s. 672.47(1). Challenges to criminal review board decisions are heard by the provincial or territorial court of appeal; see *ibid.*, s. 672.72(1).

⁵³ *Ibid.*, s. 672.55(1).

⁵⁴ *Ibid.*, s. 672.54.

⁵⁵ *Ibid.*, ss. 672.55(1) and 672.56(1).

⁵⁶ *Ibid.*, s. 672.81(1).

⁵⁷ *Ibid.*, s. 672.54(a).

uncommon for psychiatric patients to challenge their physician's finding that they are incapable, relatively few of these challenges are upheld by the CCB and even fewer are upheld by the courts. An earlier study of two Ontario psychiatric hospitals found that patients challenged 21 per cent of the findings of treatment incapacity to the CCB.⁵⁸ However, the CCB and its predecessors⁵⁹ overturned the incapacity findings in only five (1.5%) of the 334 applications made from these two hospitals between January 1, 1990 and December 31, 1999.⁶⁰ The issue in all of these capacity challenges related to medications, rather than other types of treatment.⁶¹ The average delay from the date of treatment refusal until treatment initiation was twenty-five days for patients who applied to the CCB and its predecessors but did not subsequently appeal to the courts. The authors estimated that the cost of hospitalizing these patients without treating them pending a Board decision was \$2,534,000. This estimate does not include legal fees and staff time in preparing for and presenting at a Board hearing.⁶²

During this ten-year period, fifteen patients appealed a Board confirmation of the finding of treatment incapacity in the courts. Three of these patients withdrew their appeal and accepted treatment, two absconded from the hospital, and two were found to no longer meet the criteria for involuntary admission and promptly discharged themselves contrary to medical advice.⁶³ The courts confirmed the finding of incapacity in all eight cases that they heard. Thus, eleven of the fifteen patients who appealed to the courts were eventually treated and the

⁵⁸ Michelle Kelly *et al.*, "Treatment Delays for Involuntary Psychiatric Patients Associated With Reviews of Treatment Capacity" (2002) 47(2) Can. J. Psychiatry 181 at 182. Although the study covered a ten-year period, the reported ratio of challenges to the total number of patients found to be incapable was limited to 1998 and 1999, as these were the only years in which all of the treatment incapacity determinations were recorded.

⁵⁹ At the outset of the study period, hospitalized psychiatric patients challenged treatment incapacity findings to the "review boards" under the predecessor to the current *MHA*. With the proclamation of the *CTA*, *supra* note 18, on April 3, 1995, challenges to findings of incapacity were heard by the "Consent and Capacity Review Boards." After this Act was repealed and replaced by the *HCCA* on March 29, 1996, challenges to treatment incapacity findings were addressed by the "Consent and Capacity Boards."

⁶⁰ Kelly, *supra* note 58 at 183. The 334 applications were made by 237 patients, with 1 patient making 11 applications during this period. All of the patients were diagnosed as having a psychotic disorder; see *ibid.* at 182.

⁶¹ *Ibid.*

⁶² *Ibid.* at 183-84.

⁶³ *Ibid.*; one of these patients committed suicide by self-visceration shortly after leaving the hospital.

average delay in initiating treatment was 253 days. The authors estimated that the additional cost of hospitalizing these fifteen patients without treating them from a Board confirmation of incapacity until the court ruling or discharge from hospital was \$1,333,000.⁶⁴

This study of two psychiatric hospitals in the 1990s suggests that the Ontario courts only rarely overturned a physician's initial determination that a psychiatric patient was incapable of making treatment decisions.⁶⁵ We could not be sure, however, if this study simply reflected psychiatric and legal practice in the two communities, rather than the situation throughout the province. The current study encompassing all Ontario psychiatric facilities was undertaken to determine the total number of cases between 1990 and 2005 in which the courts overturned a finding of treatment incapacity or were required to address related issues.

B) Study Method

We used Quicklaw to identify all reported cases in which a psychiatric patient's treatment capacity was addressed by an Ontario court. At the outset of our sixteen-year study period, the treatment capacity of psychiatric patients and related issues were governed by the predecessor to the current *MHA*. As of April 3, 1995, these issues were governed by the *CTA*.⁶⁶ That Act was repealed, however, and replaced by the *HCCA* on March 29, 1996. Consequently, it was necessary to search the relevant sections of these three statutes in the Quicklaw database.⁶⁷ The six cases found in the search were examined to identify those which fit our study parameters. This list of cases was then sent to several lawyers, and to forensic psychiatrists working in Ontario inpatient units. We asked these key stakeholders if they knew of any relevant cases that were not included in our list.

We soon realized from the *Starson* case that there was considerable information in the public domain about the psychiatric history of these patients, both prior to and following these court proceedings.

⁶⁴ *Ibid.* at 184.

⁶⁵ The results of this study are consistent with those in several other jurisdictions; see F. DeLand and N. Borenstein, "Medicine Court, II: Rivers in Practice" (1990) 147(1) *Am. J. Psychiatry* 38; Shelley Levin, John Brekke and P. Thomas, "A Controlled Comparison of Involuntary Hospitalized Medication Refusers and Acceptors" (1991) 19(2) *Bull. Am. Acad. Psychiatry & Law* 161 at 164; and Paul S. Appelbaum, *Almost a Revolution: Mental Health Law and the Limits of Change* (New York: Oxford University Press, 1994) at 114-63.

⁶⁶ *CTA*, *supra* note 18.

⁶⁷ The search terms that were used are listed in Appendix 1 of the paper.

Consequently, we searched for any reference to the identified patients in the records of the “Review Boards” under the *MHA*, the “Consent and Capacity Review Boards” under the *CTA*, the “Consent and Capacity Boards” under the *HCCA*, and the Ontario criminal review boards. We also attempted to locate all public documents pertaining to these patients, even if the source predated 1990. Media reports were identified using Google. A standardized protocol was developed for recording information in order to compile a comprehensive account of the patient’s demographic profile, psychiatric history, and criminal and mental health law involvement. As will become apparent, the amount of information in the public domain varied considerably among the six cases.

C) The Search Results

We identified six cases over the sixteen-year study period. In one other case,⁶⁸ the Court ordered a rehearing of the treatment capacity issue by a differently constituted CCB. This new CCB confirmed the psychiatrist’s initial finding of treatment incapacity and the patient accepted the treatment without further appeal. Consequently, this case is not included in the following review. The six cases were found through the Quicklaw search, and the key stakeholders did not identify any additional cases.

In the first set of cases discussed, *Starson v. Swayze*, *Sevels v. Cameron*⁶⁹ and *Neto v. Klukach*,⁷⁰ the courts rejected the psychiatrist’s finding and a Board confirmation that the patient was incapable of making treatment decisions. The second set of cases, *Fleming v. Reid*

⁶⁸ *Boimier v. Swaminath*, [2003] 124 A.C.W.S. (3d) 183 (Ont. Sup.Ct.J.).

⁶⁹ [1995] O.J. No. 381 (Gen. Div.) [*Sevels* 1995]. While we characterized *Sevels* as a treatment capacity case, it could also be viewed as turning on the patient’s prior expressed wish. The Review Board (the predecessor to the CCB) had accepted the psychiatrists’ evidence that Sevels had not been competent since the onset of his disease in 1965. Accordingly, it concluded that Sevels could not have subsequently expressed an apparently competent wish. Rather than directly addressing the merits of this assessment, the Court stated that the Review Board had no statutory authority to reconstruct Sevels’ past clinical condition. The legislation empowered Sevels’ substitute decision-maker to determine whether he was apparently competent when he had expressed the wish to refuse treatment. Specifically, the Court stated in *ibid.* at para. 16, “The Board has no jurisdiction ... to substitute its view of the patient’s apparent mental competence for the view of the substitute consent-giver.” Thus, the case turned on Sevels’ competency at the time of his prior expressed refusal, as assessed by his substitute decision-maker.

⁷⁰ (2004), 12 Admin. L.R. (4th) 101 (Ont. Sup.Ct.J.) [*Neto*].

and *Fleming v. Gallagher*,⁷¹ addressed the impact of a patient's prior expressed wish regarding treatment once he or she becomes incapable. In each of the five cases, the patient was eventually treated with psychotropic medication and his or her condition improved.

The last case, *Conway v. Jacques*,⁷² addressed Conway's capacity to make treatment decisions as of 2004 and the relevance of the numerous prior findings of treatment incapacity. Conway's various interrelated legal proceedings included, among other things, his capacity to consent, his capacity when he expressed a prior wish to forgo treatment, the applicability of his prior expressed wishes, procedural and evidentiary challenges, and several claims under the *Charter*. While Conway has avoided almost all efforts to treat him with psychotropic medication, he has now been detained for over twenty-five years. His condition has not improved and there appears to be little prospect that he will be released in the immediate future.

D) Judicial Reversals of Treatment Incapacity Findings

a) Scott Starson

In 1993, at the age of forty, Scott Jeffery Schutzman legally changed his name to Scott Starson. He had been a gifted student and graduated from Ryerson Polytechnical Institute with an electrical engineering degree in 1976. He worked for an electrical engineering company and rose to the position of national sales manager. Although he never pursued a graduate degree or held an academic position, Starson had an exceptional scientific mind. He wrote several scholarly articles on physics, publishing one article on anti-gravity with a leading Stanford University physics professor. Sometime in the 1980s, Starson's behaviour became erratic and his career declined. While Starson held some other jobs for short periods of time, his mother reported that he was unemployed after the late 1980s.⁷³

Starson was first admitted to a psychiatric hospital at the age of twenty-nine in 1985. Over the next thirteen years, he was hospitalized an additional nineteen times and was convicted of various criminal offences, mostly making harassing phone calls and uttering threats. In July 1998, Starson was again charged for uttering death threats. When

⁷¹ These two cases were heard and reported together, and were indexed under *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (C.A.) [*Reid*].

⁷² (2005), 250 D.L.R. (4th) 178 (Ont. Sup.Ct.J.) [*Conway*].

⁷³ Christina Spencer, "In the Name of Freedom" *MD Canada* (September/October 2003) 38 at 42.

he was found to be unfit to stand trial, the court ordered that he be detained and treated. Starson responded well to the psychotropic medications and, when returned to the court, was found fit to stand trial. In the subsequent criminal trial, Starson was found to be NCR and was detained in a psychiatric facility. As indicated, while the Criminal Review Board controlled the length and conditions of Starson's detention, it had no authority to impose treatment on him.⁷⁴ Rather, treatment decisions fell under the *HCCA*'s consent and capacity provisions.

Although Starson had responded well to the medications that he had been forced to take pursuant to the *Criminal Code*'s fitness provisions,⁷⁵ he refused these medications on admission to the psychiatric facility. Starson claimed that the medications slowed down his brain and prevented him from carrying on his scientific research. According to his mother, however, Starson had only written scientific papers while on his medication, prior to 1998.⁷⁶ Since Starson's treatment was now governed by the *HCCA*, he could refuse treatment if he was judged to be capable. Starson's psychiatrists were reported to have diagnosed him as having a bipolar disorder.⁷⁷ They indicated that Starson's delusional state prevented him from understanding the information about the proposed medications and from appreciating that he was mentally ill and that his mental condition would deteriorate without medication. Consequently, they concluded that he was incapable of consenting or refusing consent to the proposed treatment. Starson applied to the CCB to review the finding of treatment incapacity. When the CCB upheld the psychiatrists' finding on January 20, 1999, Starson appealed to the Superior Court of Justice.

The Court overturned the CCB ruling, and criticized the Board on various grounds, including: relying on the psychiatrists' testimony about Starson's criminal history rather than on original documents; concluding that Starson was incapable because some of his thinking was grandiose and delusional; failing to adequately consider letters

⁷⁴ *Criminal Code*, *supra* note 9, s. 672.55(1).

⁷⁵ *Ibid.*, s. 672.58.

⁷⁶ Juliet O'Neill, "The Patient Who Won't Take His Medicine" *The Ottawa Citizen* (6 June 2003) A1.

⁷⁷ There was some uncertainty in the legal proceedings as to Starson's diagnosis. In 2003, the Supreme Court of Canada reported that Starson was being treated for a bipolar disorder in 1998; see *Starson*, *supra* note 1 at 722. However, the next year, the Ontario Court of Appeal reported that Starson suffered from a schizoaffective disorder; see *R. v. Starson (S.)* (2004), 184 O.A.C. 338 at 341 (C.A.). This condition is characterized by periodic mood cycling in addition to the typical symptoms of schizophrenia.

from Starson's colleagues attesting to his brilliant mind; and finding that Starson failed to understand the information and appreciate the consequences of the treatment decision, rather than assessing his *ability* in these respects.⁷⁸ The Court stated that the Board failed to properly apply the statutory criteria for assessing capacity, relying instead on its subjective view of what would be in Starson's best interests.⁷⁹ Starson's doctors appealed the trial judgment. The Ontario Court of Appeal affirmed the trial judgment,⁸⁰ and this decision was appealed to the Supreme Court of Canada.⁸¹

The majority of the Supreme Court of Canada upheld the lower court decisions that the Board had unreasonably concluded that Starson was incapable. The majority stated that psychiatric patients need not agree with their psychiatrist's diagnosis, describe their condition as a mental illness or view it in negative terms. Rather, patients are only required to recognize that they are affected by their mental condition.⁸² After reviewing the evidence, the majority stated that Starson acknowledged that he had a mental condition and appreciated the purported benefits of the proposed medication. Consequently, the Board had no basis for finding that "Starson lacked awareness of his condition or that he failed to appreciate the consequences of treatment."⁸³ The majority also agreed with the trial judge that the Board had allowed its assessment of Starson's "best interest to improperly influence its finding of incapacity."⁸⁴ Finally, it was critical of the Board's reliance on "hearsay evidence" and stated that no new evidence was admissible on appeal from the Board's decision.⁸⁵

The dissenting justices held that there had been no basis for overturning the Board's finding that Starson was incapable. There was ample evidence that Starson was in almost total denial of his mental illness.⁸⁶ This was compounded by his inability, because of his delusional state, to understand the information relevant to making a

⁷⁸ *Starson v. Swayze* (1999), 22 Admin. L.R. (3d) 211 at 221, 224, 235 and 236 (Ont. Sup.Ct.J.).

⁷⁹ *Ibid.* at 234-35.

⁸⁰ *Starson v. Swayze* (2001), 33 Admin. L.R. (3d) 315 (Ont. C.A.).

⁸¹ For a detailed discussion of the Supreme Court decision and its implications, see Sklar, *supra* note 12.

⁸² *Starson*, *supra* note 1 at 761-62; although the majority appears to conflate the two components of the capacity test at this point, the paragraph seems to address both components.

⁸³ *Ibid.* at 772.

⁸⁴ *Ibid.* at 774-75.

⁸⁵ *Ibid.* at 775-77.

⁸⁶ *Ibid.* at 736.

treatment decision. The dissent noted that Starson talked about running “Starson Corporation” from inside his inpatient unit, insisted that he was on the leading edge of building a starship, claimed to be a world-class skier and arm-wrestler, and asserted that he communicated with extraterrestrial beings.⁸⁷ The dissent held that there was also ample evidence that Starson lacked the ability to appreciate: that the proposed medications might be beneficial; that he would be unlikely to return to his previous level of functioning without medication; that his condition would deteriorate further; and that without treatment he would not become well enough to be released.⁸⁸

Shortly after the Supreme Court of Canada decision on his capacity, Starson applied to the Ontario Criminal Review Board to be released from the psychiatric facility. It refused the application, concluding that Starson posed a significant threat to the public.⁸⁹ Starson appealed. The Ontario Court of Appeal upheld the Criminal Review Board’s decision, accepting that Starson would return to his threatening and intimidating behaviour unless he was closely confined and monitored.⁹⁰ The ongoing symptoms of Starson’s untreated mental illness precluded his release from hospital.⁹¹ However, the fact that Starson suffered from a serious mental illness that rendered him a danger to the public did not provide any authority to treat him. Nor would it matter if Starson was now found incapable of making treatment decisions. Having been found to be capable in 1998 when he refused the medication, this prior wish now governed his treatment.

Within twenty months of the Supreme Court’s decision, Starson’s physical and mental health had deteriorated profoundly. By February 2005, Starson was emaciated, dehydrated, and at risk of imminent kidney failure and possible death. Starson’s psychiatrist found him to be incapable. Starson appealed to the CCB, arguing that the Supreme Court had found him to be capable and that his psychiatrist had no authority to reach a contrary conclusion. The Board noted that an individual’s capacity can change over time and upheld the psychiatrist’s position that Starson was unable to make treatment decisions.⁹² Since Starson was incapable, the consent of his substitute decision-maker, his

⁸⁷ *Ibid.* at 728.

⁸⁸ *Ibid.* at 736-53.

⁸⁹ *Schutzman* 2005, *supra* note 4 at para. 30.

⁹⁰ *R. v. Starson* (2004), 184 O.A.C. 338 at 346 (C.A.).

⁹¹ In 2004, Starson again applied to the Ontario Criminal Review Board for release from the psychiatric facility. The Board denied Starson’s application and the Court of Appeal upheld the Board’s decision in a three-sentence judgment; see *Ontario v. Schutzman*, [2005] O.J. No. 2170 (C.A.) (QL).

⁹² *(Re) Professor S.*, [2005] O.C.C.B.D. No. 49 at paras. 30 and 34.

mother, was required. Although not explicitly stated in the record, presumably she concluded that Starson's prior expressed treatment refusal was no longer applicable to his perilous condition and thus she felt bound to exercise substitute consent based on his best interests. She consented to treatment with long-acting injections of antipsychotic medications starting on May 10, 2005.

By the time of Starson's August 2005 Criminal Review Board hearing, his mental and physical health had improved dramatically.⁹³ As Starson's condition improved over the next two years, the Criminal Review Board granted him passes to leave the hospital grounds for short periods.⁹⁴ In July 2007, the Criminal Review Board permitted Starson to live in the community in approved accommodation, subject to the obligation to report to his treatment team not less than once a month.⁹⁵ Starson had to be readmitted to hospital in October 2007⁹⁶ and March 2008.⁹⁷ Starson's medication was stopped in May 2008, after he sought a new CCB hearing on the issue of his capacity. By September 2008, Starson's mental health had deteriorated to the point that he had to be readmitted to secure custody.⁹⁸

b) Edwin Sevels

Edwin Sevels was born in 1943 and was first hospitalized for having schizophrenia or a schizoaffective disorder at the age of twenty-two. He was subsequently detained on seven occasions in Oak Ridge, a maximum security psychiatric facility, before being admitted on a warrant of remand in October 1991. The underlying *Criminal Code* charges were dropped and Sevels was detained as an involuntary patient under the *MHA*. Since Sevels was not competent to make treatment decisions on his own behalf, the Official Guardian was appointed his substitute decision-maker.

Sevels' psychiatrist wanted to treat him with neuroleptic medication to control the symptoms of his paranoid schizophrenia. The Official Guardian refused consent, however, because a relative had reported that Sevels had previously refused treatment while apparently

⁹³ *Schutzman* 2005, *supra* note 4 at paras. 21, 31 and 33.

⁹⁴ *Schutzman* 2006, *supra* note 6 at para. 30.

⁹⁵ *(Re) Starson*, [2007] O.R.B.D. No. 1631 at para. 37.

⁹⁶ *(Re) Schutzman*, [2008] O.R.B.D. No. 867 at paras. 10 and 11.

⁹⁷ *(Re) Schutzman*, [2008] O.R.B.D. No. 1206 at paras. 2 and 7-13; this readmission was precipitated by Starson's failure to report for his medications.

⁹⁸ *Starson v. Pearce*, [2009] O.J. No. 21 at para. 11 (Sup. Ct. J.).

competent.⁹⁹ At that time, section 2(6) of the *MHA* required substitute decision-makers to act in accordance with the patient's prior apparently competent wish or, if there was no such wish, in accordance with the patient's best interests.¹⁰⁰ Sevels' psychiatrists argued that since he had not been competent from the onset of his illness in 1965, he could not have expressed a prior competent wish to forgo treatment. On January 26, 1994, the Review Board (the *MHA* predecessor to the CCB) ordered that Sevels receive the proposed medications.¹⁰¹ Sevels appealed the Review Board order.

Sevels' psychiatrist then sought an interim court order, permitting Sevels to be medicated pending the outcome of his appeal.¹⁰² At this point, Sevels had been detained in involuntary seclusion for 404 days because of his extremely violent behaviour. The Court accepted that the proposed medications would normalize Sevels' thinking, stabilize his mood, lessen his violent behaviour, and prevent further deterioration of his mental condition. As well, the Court noted that Sevels had previously responded well to the proposed medications, suffering few side effects.¹⁰³ Nevertheless, the Court viewed itself as bound by the 1991 Ontario Court of Appeal decision in *Reid*,¹⁰⁴ which had held that medicating patients without considering their prior competent wish to refuse the treatment constituted an unjustifiable violation of their *Charter* rights.

The Court reluctantly denied the psychiatrist's application for an interim treatment order and called for the appeal to be expedited.¹⁰⁵ In closing, the Court expressed its disagreement with the state of the law in blunt terms:

... [I]t surely cannot be the intended result of the ... Charter of Rights and Freedoms that persons who are entrapped in the cage of their mental illness ... be for prolonged periods caged and warehoused in mental health facilities where the key to their necessary and involuntary seclusion is available with relatively little likelihood of substantial risk.¹⁰⁶

⁹⁹ *Sevels v. Cameron*, [1994] O.J. No. 2123 at para. 8 (Gen. Div.) [*Sevels* 1994].

¹⁰⁰ This test is similar to the current principles governing the exercise of substitute consent under the *HCCA*.

¹⁰¹ *Sevels* 1994, *supra* note 99 at paras. 1 and 9.

¹⁰² *Ibid.* at para 1. These orders were governed by the *MHA*, *supra* note 13, s. 50(11). This section was repealed on April 3, 1995, when the *CTA* came into force; see *Consent and Capacity Amendment Act*, *supra* note 17, s. 20(40).

¹⁰³ *Sevels* 1994, *supra* note 99 at para. 1 and 3.

¹⁰⁴ *Ibid.* at para. 12.

¹⁰⁵ *Ibid.* at paras. 15 and 17.

¹⁰⁶ *Ibid.* at para. 15.

The judge who heard the application for the interim treatment order presided in the appeal from the Review Board's 1994 order.¹⁰⁷ He ruled that the Review Board had no authority to reconstruct Sevels' mental health history. Rather, section 6 of the *MHA* empowered the Official Guardian, as Sevels' substitute decision-maker, to determine if Sevels had been "apparently mentally competent" when he expressed the wish to refuse treatment. The Court granted Sevels' appeal and quashed the Board's treatment order. Again, the Court expressed its concern about the legislation and called for amendments.¹⁰⁸

Sevels remained untreated and his mental condition deteriorated. In February 1997, Sevels attacked and seriously injured a male staff member. Sevels' psychiatrists again sought substitute consent from the Official Guardian.¹⁰⁹ For reasons which are not apparent from the public record, the Official Guardian reversed its position and consented to Sevels' treatment. Sevels was treated in March 1997, but only after sixty-five months of involuntary detention, at least thirteen of which were in seclusion. His condition improved rapidly and he was moved out of involuntary seclusion. Sevels' condition continued to improve on the medications and he was transferred to a rehabilitation program in 2003.¹¹⁰

In December 2003, Sevels was discharged from hospital on a Community Treatment Order (CTO), which included continuing treatment with antipsychotic medications. On one occasion when Sevels missed his scheduled injection, he became argumentative and aggressive. On another occasion, Sevels breached his CTO and had to be returned to the hospital. Sevels sought voluntary admission at one point because he did not have adequate winter housing.¹¹¹ In 2004 and 2005, Sevels applied without success to the CCB for a ruling that he was capable of making his own treatment decisions.¹¹² He also applied to the CCB in both years seeking a review of his CTO.¹¹³ Sevels'

¹⁰⁷ *Sevels* 1995, *supra* note 69.

¹⁰⁸ *Ibid.* at paras. 16, 17 and 19.

¹⁰⁹ *(Re) S.*, [2005] O.C.C.B.D. No. 326 at para. 13.

¹¹⁰ *Ibid.* at paras. 13 and 18.

¹¹¹ *Ibid.* at paras. 18-21, and 23.

¹¹² *(Re) E.S.*, [2004] O.C.C.B.D. No. 212; and *(Re) E.S.*, [2005] O.C.C.B.D. No. 231.

¹¹³ *(Re) E.S.*, [2004] O.C.C.B.D. No. 75; *(Re) E.S.*, [2004] O.C.C.B.D. No. 557; and *(Re) E.S.*, [2005] O.C.C.B.D. No. 74.

subsequent appeals in 2007¹¹⁴ and 2008¹¹⁵ to the Ontario Superior Court were dismissed. As of April 2008, Sevels was living in the community on a CTO without major difficulties.¹¹⁶

c) *Maria Neto*

Maria Neto was diagnosed as having a bipolar disorder at the age of fifteen in Portugal and, except for a three-year period, had taken lithium, the standard drug treatment. In 1998, Neto immigrated to Canada at the age of thirty-three. She married and had a son in 1999.¹¹⁷ When she separated from her husband, she was awarded custody provided that she lived with her mother and continued to take her medications. She was admitted to a psychiatric facility on three occasions between 2000 and 2002. Early in January 2003, Neto became agitated and began acting strangely. When she went to the emergency department on January 13, she told the doctors that her family was trying to destroy her and that she had immense powers. She was admitted to hospital and restrained. She remained agitated, expressed delusional beliefs about her medications and denied that she had a bipolar disorder.¹¹⁸

Neto's psychiatrist, Dr. Klukach, concluded that she was incapable of making treatment decisions. He obtained consent from Neto's aunt, who had agreed to serve as her substitute decision-maker. Neto challenged both her status as an involuntary patient and Klukach's finding that she was incapable. The CCB upheld her involuntary status on the basis that she was at risk of serious mental deterioration if she did not remain hospitalized.¹¹⁹ In terms of treatment capacity, the CCB held that Neto had the ability to understand the information relevant to making the proposed treatment decision.¹²⁰ However, the majority of the CCB found that she did not have the ability to appreciate the reasonably foreseeable consequences of refusing consent.¹²¹ Neto appealed the CCB's confirmation of her treatment incapacity to the Ontario Superior Court.

¹¹⁴ *Sevels v. Fleming*, [2007] 157 A.C.W.S. (3d) 545 (Ont. Sup. Ct. J.); this appeal challenged the CCB's finding that Sevels was incapable of consenting or refusing consent to treatment.

¹¹⁵ *Sevels v. Fleming*, [2008] O.J. No. 1296 (Sup. Ct. J.); the issue in this appeal cannot be determined from the public record.

¹¹⁶ *Ibid.*

¹¹⁷ *Neto*, *supra* note 70 at 102.

¹¹⁸ *Ibid.* at 103.

¹¹⁹ *(Re) Neto*, [Jan. 24, 2003] O.C.C.B. at 15.

¹²⁰ *Neto*, *supra* note 70 at 103.

¹²¹ *Ibid.*

The Court stated that the key issue in determining if patients can appreciate the consequences of their treatment decisions is whether they have “the ability to evaluate, not just understand,” the relevant information.¹²² In resolving this issue, the Court applied three common indicators that McLachlin C.J.C. had quoted with approval in *Starson*.¹²³ First, the patient must be “able to acknowledge the fact that the condition for which treatment is recommended may affect him or her.” The Court found that Neto, while not describing herself as mentally ill, accepted that she was different and that lithium stabilized her symptoms. Second, the patient must be “able to assess how the proposed treatment and its alternatives, including no treatment, could affect” his or her life or quality of life. The Court found that Neto could assess the impact of her decision, which was based on her previous “negative experiences with antipsychotic medications.” Third, the patient’s decision “must not be ‘substantially’ based on delusional thinking.” While Neto had certain delusional thoughts, such as believing at one point that she was the Queen of Portugal, this was not related to her objections to the medication. Moreover, even after Neto had been given antipsychotic medications that made her outwardly calmer and more coherent, she reiterated her opposition to these drugs.¹²⁴

Accordingly, the Court held that Neto had the ability to appreciate the consequences of her treatment decisions. It overturned the CCB finding and held that Neto was competent in regard to treatment.¹²⁵ By this time, Neto had been discharged from the hospital and had consented to take lithium for a period of time. Neto subsequently became pregnant and, as medically recommended, stopped taking lithium. The public record concerning Neto ends at this point.

E) Prior Expressed Wishes

a) Introduction

George Reid and Kenneth Gallagher share a similar criminal and institutional history. Both were detained involuntarily in psychiatric facilities for over twenty years after being found not guilty by reason of

¹²² *Ibid.* at 104.

¹²³ *Starson*, *supra* note 1 at 735-36. The Court in *Neto* stated at 104 that while McLachlin, C.J.C. dissented in *Starson*, it was not related to this test, which was based on Brian F. Hoffman, *The Law of Consent to Treatment in Ontario*, 2nd ed. (Toronto: Butterworths Canada Ltd., 1997) at 18.

¹²⁴ *Neto*, *supra* note 70 at 109.

¹²⁵ *Ibid.* at 113.

insanity for a serious criminal offence. Both were precluded from receiving treatment for much of this twenty-year period, primarily because their prior apparently competent wish was given precedence over their best interests. As with Starson, Reid and Gallagher were only treated after their situation had become desperate. Both men responded well to the medications that they had opposed, and both have been successfully integrated into society. In order to make their complex histories easier to follow, the *Reid* and *Gallagher* cases are outlined within specific timeframes.

b) George Reid

i) May 1978 to September 1983

George Reid was born in March 1953 and had a history of behavioural problems from a young age. Between May 1978 and September 1983, he was admitted to various psychiatric institutions on twenty-one occasions with a diagnosis of schizophrenia complicated by substance abuse. Reid was charged with robbery in September 1983 and subsequently found not guilty by reason of insanity. He was placed on a Lieutenant Governor's warrant and remanded to the Oak Ridge mental health facility in Penetanguishene.

ii) September 1983 to September 1987

During the first few years, Reid sporadically took his antipsychotic medications. When he went off his medication, he became floridly delusional. For example, Reid claimed that he had come from Mars to Earth before other men and that the hospital staff was trying to poison him. Reid's case was reviewed annually by the Review Board, which continued his detention because he remained a risk to the public and himself. He was transferred to a medium security facility at one point, but was returned to Oak Ridge for violating his off-grounds privileges.

In April 1987, Reid's father consented to his son's treatment with long-acting injections of fluphenazine, an antipsychotic medication, but withdrew consent after the second injection. Reid remained unmedicated and his condition deteriorated. At that point, Reid's psychiatrist, Dr. Fleming, determined that he was not competent to consent to psychiatric treatment. Reid appealed Fleming's finding to the Review Board and no treatment could be initiated until it was resolved.

iii) *February 1988 to March 1990*

The Review Board confirmed Fleming's finding that Reid was incapable of making treatment decisions. Consequently, the consent of Reid's substitute decision-maker was sought. Since Reid's family no longer wanted to be involved, the Official Guardian became Reid's substitute decision-maker. After an investigation, the Official Guardian concluded that Reid had expressed a wish in 1982, while apparently competent, not to be treated with antipsychotic medication. In accordance with this wish, the Official Guardian refused consent to the proposed treatment on Reid's behalf.¹²⁶

Fleming applied to the Review Board for a treatment order under section 35a(1)(b) of the *MHA*. Section 35a(2) required the application to include a signed statement with written reasons from both Fleming and a psychiatrist who was not on the facility's medical staff. The statements had to indicate that the doctors had examined Reid and were of the opinion that:

- (i) Reid's mental condition would or likely would be substantially improved by the specified psychiatric treatment;
- (ii) his mental condition would not or likely would not improve without the treatment;
- (iii) the anticipated benefits of the treatment would outweigh the risk of harm to Reid; and
- (iv) the treatment was the least restrictive and least intrusive treatment that would meet the requirements of (i), (ii) and (iii).

Section 35a(4) of the *MHA* authorized the Review Board to order the specified treatment if it was satisfied that these criteria were met. An involuntary patient's prior apparently competent wish was not a relevant factor in this determination. The Review Board authorized the proposed treatment which was initiated in April 1989.¹²⁷

¹²⁶ The *Mental Health Act*, R.S.O. 1980, c. 262 was subject to major amendments in June 1987 in the *Mental Health Amendment Act, 1987*, S.O. 1987, c. 37. It was pursuant to these amendments that the Official Guardian became Reid's substitute decision-maker and was required to refuse consent to the medications based on Reid's prior apparently competent refusal; see *MHA*, R.S.O. 1980, c. 262, ss. 1a(1)8 and 1a(6), as am. by *Mental Health Amendment Act, 1987*, S.O. 1987, c. 37, s. 2.

¹²⁷ (*Re Reid*, [Feb. 7, 1989] Lieutenant Governor's Board of Review (L.G.B.R.) at 6.

Reid appealed the Review Board's decision to the District Court,¹²⁸ claiming that section 35(a) violated his right to security of the person under section 7 of the *Charter* and his equality rights under section 15. In the interim, Reid was receiving medication, despite his objections, and was responding well. By the end of 1989, he had shown "rapid and significant progress."¹²⁹ Reid's condition continued to improve, and he was transferred to a medium security facility in October 1990.¹³⁰

iv) May 1990

The Ontario District Court denied Reid's appeal. While section 35a of the *MHA* infringed Reid's right to security of the person, it did not do so in a manner that was inconsistent with the principles of fundamental justice. The scheme established by the *MHA* was consistent with the state's *parens patriae* power – namely, its authority to protect those who cannot protect themselves. Consequently there was no violation of Reid's section 7 *Charter* rights.¹³¹ The Court also found that the *MHA* did not discriminate against incompetent involuntary patients. The distinctions that the Act drew between these patients and voluntary competent patients were appropriate given their different needs. It was illogical to assume that these categories of patients should be treated identically. The Court concluded accordingly that the *MHA* did not violate Reid's equality rights under section 15 of the *Charter*.¹³²

Reid's mental condition and behaviour continued to improve while on medication. He was granted additional privileges in the community and began creating artwork. He was described as being friendly with the staff and other patients, and the hospital recommended modest changes in the conditions of his detention.¹³³ Nevertheless, Reid appealed the District Court decision to the Ontario Court of Appeal.

v) June 1991

The Court of Appeal stated that the *MHA* provisions authorizing the forced treatment of involuntary patients obviously infringed their section 7 *Charter* right to security of the person.¹³⁴ Moreover, the Court ruled that this infringement was inconsistent with the principles of

¹²⁸ *Fleming v. Reid* (1990), 73 O.R. (2d) 169 (Dist. Ct.) [*Reid* 1990].

¹²⁹ (*Re*) *Reid*, [Mar. 8, 1990] L.G.B.R. at 4.

¹³⁰ (*Re*) *Reid*, [Jan. 22, 1991] L.G.B.R. at 4 [*Reid* 1991].

¹³¹ *Reid* 1990, *supra* note 128 at 187-89.

¹³² *Ibid.* at 189-90.

¹³³ *Reid* 1991, *supra* note 130 at 5 and 7.

¹³⁴ *Reid*, *supra* note 71 at 75. In the Court's words, "Few medical procedures are

fundamental justice, because it denied involuntary patients any opportunity to have their prior competent wishes to forgo treatment presented to or considered by the Review Board. The Court noted the legislation created a system of substitute consent which purported to respect the prior competent wishes of incompetent patients only to render those wishes “entirely meaningless” when a treatment order was sought.¹³⁵ The Court stated that the *parens patriae* doctrine provided no authority for overruling an involuntary patient’s prior competent wish to refuse treatment. Accordingly, the Court held that the *MHA* violated Reid’s section 7 *Charter* right to security of the person.¹³⁶ Further, the Court held that this *Charter* violation could not be justified under section 1. The violation was neither reasonable nor demonstrably justified in a free and democratic society, because the *MHA* gave involuntary patients no opportunity to have their reasons for not wanting the treatment presented to the Review Board.¹³⁷

Given its conclusion on section 7, the Court stated it was not necessary to analyze whether the provisions also violated Reid’s equality rights under section 15 of the *Charter*. The Court of Appeal struck down the offending provisions of the *MHA* and upheld the Official Guardian’s decision to refuse consent to antipsychotic medication.

vi) July 1991 to July 1996

Reid refused to take the proposed medications and, due to the Court of Appeal decision, could not be treated against his will. There was no significant deterioration in Reid’s mental condition or behaviour for approximately nine months. However, by August 1992, Reid suffered a relapse and became increasingly violent and physically threatening. The treatment team could do little more than observe Reid’s decline. Within twelve months, Reid had to be transferred back to the maximum security facility and lost his community privileges.¹³⁸

Reid’s mental condition continued to deteriorate. In September 1995, the Criminal Review Board stated that Reid was grossly psychotic and subject to auditory and visual hallucinations. He was defiant, hostile and agitated, which rendered him unpredictable and

more intrusive than the forcible injection of powerful mind-altering drugs which are often accompanied by severe and sometimes irreversible adverse side effects.”

¹³⁵ *Ibid.* at 93.

¹³⁶ *Ibid.* at 88.

¹³⁷ *Ibid.* at 95-96.

¹³⁸ *(Re) Reid*, [Oct. 19, 1992] L.G.B.R. at 3-5.

aggressive. His violence peaked in 1995, when he had to be secluded on nineteen occasions.¹³⁹

vii) *August 1996 to September 2008*

Reid's psychiatrist again found him to be incapable with regard to treatment. The exact sequence of events that followed is not apparent from the public record. Presumably, Reid sought a review. The CCB confirmed the physician's finding that Reid was incapable.¹⁴⁰ It would appear that Reid's brother became his substitute decision-maker and consented to his treatment with antipsychotic medications. It is unclear why Reid's brother did not feel bound by his prior expressed wish to forgo treatment.

It may be noteworthy that the *HCCA* had been proclaimed in force on March 29, 1996. Under section 21(1)1 of the Act, a substitute decision-maker is only bound by a patient's prior capable wish if he or she knows of it. Reid's brother may not have known of his 1982 wish to refuse antipsychotic medications, or knew of the wish but did not believe that Reid made it while capable. Similarly, a substitute decision-maker is only bound by wishes that are applicable to the current circumstances. Reid's brother may have known of the wish and believed Reid made it when he was capable, but felt that it was no longer applicable to his deteriorating condition. In these circumstances, the Act requires substitute decision makers to base treatment decisions on their assessment of the patient's best interests.

Reid did not challenge his brother's exercise of substitute consent. Reid's mental condition and behaviour slowly improved with the medications, although there were occasional compliance problems. He was transferred to a less secure psychiatric facility and was subsequently granted supervised community access.¹⁴¹ In October 2000, the Criminal Review Board reported that Reid's mental status had improved remarkably. He was complying with his treatment and using his community privileges responsibly. Consequently, the Board ordered that his privileges be broadened.¹⁴² Reid's condition continued to improve and he was given broader freedom to travel outside the institution.¹⁴³

¹³⁹ *(Re) Reid*, [Sept. 7, 1995] O.R.B. at 2 and 3.

¹⁴⁰ *(Re) Reid*, [Oct. 28, 1997] O.R.B. at 2 and 3.

¹⁴¹ *(Re) Reid*, [2001] O.R.B.D. No. 123 at paras. 10 and 16.

¹⁴² *Ibid.* at paras. 10 and 28.

¹⁴³ *(Re) Reid*, [2003] O.R.B.D. No. 305 at para. 3.

In April 2004, Reid moved into his own apartment in the community. He was described as having successfully made the transition to living on his own, and his brother continued to provide substitute consent for his treatment.¹⁴⁴ In November 2005, the Criminal Review Board granted Reid a conditional discharge.¹⁴⁵ As of September 2008, Reid was living independently in the community without any major problems.¹⁴⁶

c) *Kenneth Gallagher*¹⁴⁷

i) *1973 to 1989*

Gallagher was first admitted to a psychiatric facility in 1973, at the age of eighteen. In the next nine years, Gallagher was admitted an additional thirty-seven times to various psychiatric facilities. In May 1982, Gallagher was charged with rape and subsequently found not guilty by reason of insanity. He was remanded to a maximum security psychiatric facility in British Columbia¹⁴⁸ and diagnosed as suffering from schizophrenia, drug abuse and an antisocial personality disorder.

In 1986, Gallagher was transferred to Oak Ridge in Ontario where he began refusing to take his medications. The next year, the Ontario Review Board authorized the hospital to administer antipsychotic medication.¹⁴⁹ In 1989, Gallagher again refused to take his medications.

ii) *1989 to 1991*

Gallagher's psychiatrist, Dr. Fleming, found him to be incompetent to make treatment decisions and sought the consent of the Official Guardian which had become his substitute decision-maker. The Official

¹⁴⁴ *(Re) Reid*, [2005] O.R.B.D. No. 3 at paras. 15 and 18.

¹⁴⁵ *(Re) Reid*, [2006] O.R.B.D. No. 27 at para. 22.

¹⁴⁶ *(Re) Reid*, [2008] O.R.B.D. No. 1591 [*Reid* 2008]. In 2007, the Criminal Review Board expressed concern about Reid's occasional use of cannabis; see *(Re) Reid*, [2007] O.R.B.D. No. 1375 at paras. 8 and 21. Although Reid was reportedly using cannabis regularly at the time of his 2008 review, his psychiatrist testified that there was very little change in his clinical state, no other criminal involvement, and no threatening or violent behaviour. Consequently, the Criminal Review Board continued his conditional discharge; see *Reid* 2008, *ibid.* at paras. 13, 14 and 32.

¹⁴⁷ The patient's name is most frequently spelled Gallagher, but occasionally spelled Gallacher; for the sake of consistency, we have adopted the former spelling throughout the paper.

¹⁴⁸ *Fleming v. Gallagher*(No. 1) (1990), 74 O.R. (2d) 317 at 319 (C.A.).

¹⁴⁹ *Ibid.* at 319-20.

Guardian refused because Gallagher had expressed a wish while apparently competent to forgo the proposed medications. Fleming sought and obtained a treatment order from the Review Board authorizing the proposed treatment.¹⁵⁰ Under section 35a(4) of the *MHA*, the Board's decision turned on factors related to Gallagher's best interests, irrespective of his prior apparently competent wish. Gallagher challenged the Review Board decision on the basis that the legislation violated his *Charter* rights under sections 7 and 15. The District Court held that the provisions did not violate the *Charter*.¹⁵¹

Gallagher appealed to the Ontario Court of Appeal where his case was heard together with Reid's. As indicated above, the Court ruled that the legislation violated section 7 and could not be justified under section 1. The District Court decision was overturned, and the Review Board's treatment order was quashed.¹⁵²

iii) 1991 to 1994

Gallagher refused medication and could not be treated against his will. Gallagher became grossly psychotic, experiencing sexual delusions, and auditory and visual hallucinations. By 1992, Gallagher lost all contact with his family, who no longer wanted to be involved with his treatment. The psychiatrist who assessed Gallagher in March 1994 stated that his disturbed thought process and angry outbursts made it almost impossible to have a conversation with him. Gallagher did not know the day, the date or where he was, and was described as being "unpredictable, threatening and verbally and physically assaultive."¹⁵³ In 1994, the Criminal Review Board concluded that Gallagher's prognosis was extremely poor and feared that he would require close supervision in a maximum security facility for the rest of his life.¹⁵⁴

iv) 1997 to 2008

In October 1997, Gallagher's physicians again found him to be incapable of consenting to treatment, and the CCB upheld this finding.¹⁵⁵ When the CCB's decision was not appealed, Gallagher was immediately treated with antipsychotic medications. It is not clear from the public record why the psychiatrist and Gallagher's substitute

¹⁵⁰ *Reid*, *supra* note 71 at 83.

¹⁵¹ *Ibid.*

¹⁵² *Ibid.*

¹⁵³ *(Re) Gallagher*, [1994] O.R.B at 2.

¹⁵⁴ *Ibid.*

¹⁵⁵ *(Re) Gallagher*, [1997] O.C.C.B.

decision-maker did not feel bound by Gallagher's prior apparently competent wish to refuse treatment. They may have viewed Gallagher's prior wish as no longer applicable to the dehumanizing and dismal future he faced without medication.

Gallagher's mental and physical condition began to improve on his medications. His last recorded incident of aggression appears to have been in 1998. In 2000, Gallagher was transferred to a less restrictive forensic unit and was granted supervised community passes the next year.¹⁵⁶ As Gallagher's clinical condition continued to improve, he was granted broader freedoms including permission to live in a group home in the community, and passes for extended visits with his family in British Columbia. Although the 2006 and 2008 Criminal Review Boards emphasized the progress that Gallagher had made and supported his request for a transfer to British Columbia to live with his sister, they ordered that his conditional discharge be maintained.¹⁵⁷

F) Exhausting the Legal Remedies

As the Conway case will demonstrate, the current law gives patients virtually endless opportunities for challenging a finding of treatment incapacity by a psychiatrist or board. In the end, Conway has been detained in various psychiatric hospitals for over twenty-five years without ever receiving treatment which was readily available. It should be noted that the following synopsis includes only the most important legal proceedings related to Conway's psychiatric treatment.

a) 1983

Paul Conway was born in 1953. Prior to 1983, he had two convictions for assault, but had never been admitted to a psychiatric hospital. In September 1983, Conway was charged with raping and assaulting his aunt with a knife. He was subsequently found not guilty by reason of insanity and detained under a Lieutenant Governor's warrant at Oak Ridge.¹⁵⁸

b) 1984 to 1996

Conway was diagnosed as suffering from a psychotic illness, superimposed on a severe personality disorder. Conway refused

¹⁵⁶ *(Re) Gallagher*, [2001] O.R.B.D. No. 290 at para. 1(2)(c).

¹⁵⁷ *(Re) Gallagher*, [2006] O.R.B.D. No. 487; and *(Re) Gallagher*, [2008] O.R.B.D. No. 1021.

¹⁵⁸ *(Re) Conway*, [2003] O.R.B.D. No. 309 at paras. 1-2.

medication for his mental illness, except for a short period in 1990 when he took small doses of the antipsychotic, trifluoperazine. He vehemently denied that he was mentally ill and claimed to be a victim of the system. Conway had persistent delusions that male staff at the hospital were trying to rape him. He was aggressive and repeatedly harassed the nursing staff. Although he was transferred to less secure facilities on four occasions, he had to be returned to Oak Ridge due to various behavioural problems, including sexual impropriety.¹⁵⁹

Conway repeatedly challenged the Criminal Review Board's decisions regarding his place of confinement and the restrictive conditions of his detention. He refused to co-operate with any assessments, continued to refuse medications, and denied that he was mentally ill.¹⁶⁰

c) March 1996 to August 1998

In March 1996, Dr. Jacques found Conway to be incapable in regard to treatment and sought consent from his mother, his substitute decision-maker. She refused because section 21(1)1 of the *HCCA* required her to abide by Conway's prior capable refusal of consent. Jacques then applied to the CCB under section 37(1) of the *HCCA* to determine if Mrs. Conway had exercised substitute consent in accordance with the requirements of section 21.¹⁶¹

In February 1997, the CCB ruled that Mrs. Conway had not complied with section 21. Given the availability of new medications and the significant deterioration in Conway's condition, his prior capable refusal was inapplicable to the current circumstances. Thus, under section 21(1)2 of the *HCCA*, Mrs. Conway was required to exercise substitute consent in accordance with Conway's best interests. The CCB ordered Mrs. Conway to consent to the proposed treatment, because it was in Conway's best interests.¹⁶² Conway and his mother appealed the CCB order to the Superior Court of Justice.¹⁶³ Conway's condition continued to deteriorate. He was sexually aggressive with female staff and his violent tendencies escalated.¹⁶⁴

¹⁵⁹ *(Re) P.C.*, [2004] O.C.C.B.D. No. 156 at paras. 11, 14 and 15 [(*Re) P.C.*].

¹⁶⁰ *Conway v. Jacques* (2002), 59 O.R. (3d) 737 at 737 (C.A.) [*Conway* 2002].

¹⁶¹ *Ibid.* at 742.

¹⁶² *Ibid.* at 743-44.

¹⁶³ *HCCA*, *supra* note 10, s. 80(1).

¹⁶⁴ *(Re) Conway*, [June 5, 1998] O.R.B. at 5.

d) September 1998 to June 2002

In September 1998, the Conways sought to introduce new evidence relating to the applicability of his prior expressed refusals. The Ontario Superior Court granted their appeal and sent the case back to the CCB for a rehearing in light of the new evidence.¹⁶⁵ The original CCB panel reconvened, considered the new evidence and again concluded that Conway's prior expressed wish to refuse treatment was inapplicable. In March 2000, the CCB again ruled that Mrs. Conway had to exercise substitute consent in accordance with her son's best interests and therefore could not refuse consent to the proposed treatment. The Conways again appealed the CCB's ruling to the Superior Court of Justice.¹⁶⁶

In February 2001, the Superior Court overturned the CCB's March 2000 ruling. Essentially, the Court concluded that had Conway been competent he still would not have consented to the proposed treatment, despite his deteriorating condition and the availability of new medications.¹⁶⁷ Dr. Jacques appealed this decision to the Ontario Court of Appeal. Conway's condition continued to deteriorate, requiring frequent chemical restraint and involuntary seclusion to protect both him and the staff. The use of chemical restraints had previously prompted Conway to sue the staff for damages in battery and for violating his *Charter* rights. His suit failed.¹⁶⁸

In June 2002, the Ontario Court of Appeal overturned the Superior Court decision. The Court of Appeal stated that section 21(1)1 of the *HCCA* required substitute decision-makers to defer to the patient's prior capable wish, but only if it was applicable to the current circumstances. If the prior wish was inapplicable, the substitute decision-maker had to act in the patient's best interests and not in accordance with what the patient would have done in the new circumstances.¹⁶⁹ The Court of Appeal restored the CCB's order and directed Mrs. Conway to comply

¹⁶⁵ *Conway v. Jacques* (1998), 82 A.C.W.S. (3d) 792 (Ont. Sup. Ct. J.). In May 1997, Conway challenged holding his Criminal Review Board hearing at Oak Ridge, claiming that the oppressive atmosphere inhibited his ability to express his thoughts as a witness. The Criminal Review Board rejected the challenge. The next month, Conway sought a review of his continued detention at Oak Ridge under section 672.81(2)(a) of the *Criminal Code*. The Criminal Review Board rejected Conway's claim and continued his detention at Oak Ridge.

¹⁶⁶ *Conway v. Jacques* (2001), 32 Admin. L.R. (3d) 248 at 249-50 (Ont. Sup.Ct.J.).

¹⁶⁷ *Ibid.* at 265.

¹⁶⁸ *Conway v. Fleming* (1999), 173 D.L.R. (4th) 372 (Ont. Gen. Div.).

¹⁶⁹ *Conway* 2002, *supra* note 160 at 747-49.

within sixty days. The Court expressed concern about the unacceptable delays over the six years since Conway had been found to be incapable.¹⁷⁰ Mrs. Conway sought leave to appeal to the Supreme Court of Canada.

e) February 2003 to February 2005

The Supreme Court refused leave in February 2003.¹⁷¹ At the end of the year, the Public Guardian and Trustee replaced Mrs. Conway as his substitute decision-maker. In January 2004, the Public Guardian and Trustee consented to Conway being treated with various medications, including olanzapine in both tablet and injectable form. Conway refused to take olanzapine orally, and remained unmedicated as the drug was not then available in injectable form.¹⁷² When Conway learned in February 2004 that olanzapine was available in an injectable form, he immediately challenged Jacques' original 1996 finding that he was incapable in regard to treatment. In April 2004, the CCB again concluded that Conway was incapable. The CCB considered its earlier decisions and the 2002 Ontario Court of Appeal decision, and concluded that little had changed since 1996.¹⁷³

In February 2005, the Ontario Superior Court overturned the CCB's April 2004 finding that Conway was incapable. The CCB had relied on prior decisions that related to Mrs. Conway's exercise of substitute consent and did not adequately address whether Conway met the test of capacity under section 4(1) of the *HCCA* as of April 2004. The Court reluctantly referred the matter of Conway's capacity back to the CCB for a rehearing with a new panel, and urged the CCB to use its best efforts to conduct the new hearing within sixty days.¹⁷⁴

f) May 2005 to April 2008

Conway launched another unsuccessful *Charter* challenge to his continued detention.¹⁷⁵ The Criminal Review Board noted that Conway's condition had not improved and that he remained a risk to the public. Nevertheless, it was not in Conway's interest to remain at Oak

¹⁷⁰ *Ibid.* at 749-50.

¹⁷¹ *Conway v. Jacques* (2003), 180 O.A.C. 397, leave to appeal to S.C.C. refused, 29349 (Feb. 6, 2003).

¹⁷² *(Re) P.C.*, *supra* note 159 at para. 20.

¹⁷³ *Ibid.* at para. 21. Later that year, Conway brought several *Charter* challenges.

¹⁷⁴ *Conway v. Jacques* (2005), 250 D.L.R. (4th) 178 at 190-92 (Ont. Sup.Ct.J.).

¹⁷⁵ *(Re) Conway*, [May 24, 2005] O.R.B. at 5.

Ridge due to the impasse that existed between Conway and the staff.¹⁷⁶ The Criminal Review Board ordered Conway to be transferred to the Centre for Addiction and Mental Health (CAMH) in Toronto with some privileges. However, it also stated that if Conway's behavior necessitated his return to Oak Ridge, his hopes for eventual return to society would be lost to him for a very long time.¹⁷⁷ In 2006, Conway sought an absolute discharge from the Criminal Review Board based on constitutional and non-constitutional grounds. When the Board denied his application, Conway appealed.¹⁷⁸

In May 2007, Conway's destructive behaviour resulted in confinement in seclusion for almost three months.¹⁷⁹ The Criminal Review Board reported that Conway made significant progress following that incident and encouraged CAMH to speed up the granting of "all the privileges allowed under his disposition."¹⁸⁰ In 2008, the Ontario Court of Appeal granted, in part, Conway's appeal of the Criminal Review Board's 2006 denial of his application for an absolute discharge. The Court ordered the Criminal Review Board to hold a hearing as soon as practical to address, among other things, the treatment impasse between Conway and the CAMH staff, and the alleged *Charter* breaches.¹⁸¹

4. Discussion and Recommendations

A) Synopsis of the Findings

Previous research indicated that the CCB and its predecessors confirmed the initial treatment incapacity finding in all but 1.5% of the challenges involving psychiatric patients. Moreover, the courts upheld the initial finding in all of the subsequent appeals.¹⁸² The current study encompasses all Ontario psychiatric facilities from 1990 until 2005. It found only three cases, those of Starson, Sevels¹⁸³ and Neto, in which

¹⁷⁶ *Ibid.* at 23.

¹⁷⁷ *Ibid.* at 25.

¹⁷⁸ *R. v. Conway*, [2008] 293 D.L.R. (4th) 729 at 735-36 (Ont. C.A.) [*Conway* 2008].

¹⁷⁹ (*Re*) *Conway*, [2008] O.R.B.D. No. 29 at paras. 24, 31 and 34.

¹⁸⁰ *Ibid.* at para. 73.

¹⁸¹ *Conway* 2008, *supra* note 178 at 743-44 and 767-68. The Court of Appeal held at 750-51 that the Criminal Review Board did not have jurisdiction to grant Conway's application for an absolute discharge as a *Charter* remedy. Nevertheless, the Court stated at 751-52 that the Board could and should address Conway's underlying concerns pursuant to its statutory authority to supervise his treatment.

¹⁸² Kelly, *supra* note 58 at 183-84.

¹⁸³ As noted earlier, while Sevels raised a unique competency issue, it could also be characterized as turning on his apparently competent wish to refuse treatment.

a court overturned a confirmation of treatment incapacity by the CCB or its predecessors. In three cases, those of Reid, Gallagher and Conway, the courts did not question the confirmation of treatment incapacity, but rather held that the patients could not be treated because of their prior capable wish to refuse treatment.

Four of the patients, Starson, Sevels, Reid, and Gallagher, were eventually treated over their objections, despite an earlier court decision upholding their right to refuse treatment. They experienced a prolonged and eventually futile loss of liberty while detained completely or mostly untreated, for periods ranging from about five and one-half years for Sevels to more than ten years for Reid. During their hospitalization, Sevels, Reid and Gallagher had to be subject to long periods of involuntary seclusion. As predicted by their psychiatrists, the mental health of all four patients deteriorated without the recommended medications. Nevertheless, it was only when the patients' situations became life-threatening, dehumanizing or desperate that their treatment capacity or prior capable wish was reassessed.

The patients' clinical history made it apparent prior to the court rulings that their condition would likely improve with the proposed medications. Again, as predicted, the clinical condition of all four patients improved dramatically with the antipsychotic medications. In addition to the prolonged loss of liberty, the delays may have resulted in significantly impairing the patients' long-term mental health. Research indicates that the longer psychotic illnesses remain untreated the worse the patient's long-term prognosis, even if treatment is eventually started.¹⁸⁴

Neto was the only patient who was able to secure her release from hospital without being required to take antipsychotic medications. She did, however, take the recommended mood stabilizer, lithium. Moreover, Neto's mental illness was never as serious as that of the other five patients. She had also consistently taken lithium, with few exceptions, since first being diagnosed as a teenager. She had not committed a criminal offence and posed a risk primarily to herself. In any event, by the time her case went to court, Neto had voluntarily taken lithium and had been discharged from hospital.

¹⁸⁴ Robert W. Buchanan and William T. Carpenter, "12.1 Concept of Schizophrenia" in Benjamin J. Sadock and Virginia A. Sadock, eds., *Kaplan & Sadock's Comprehensive Textbook of Psychiatry*, vol. 1, 8th ed. (Philadelphia: Lippincott Williams & Wilkins, 2005) 1329 at 1342; and Max Marshall *et al.*, "Association Between Duration of Untreated Psychosis and Outcome in Cohorts of First-episode Patients: Systematic Review (2005) 62(9) Arch. Gen. Psychiatry 975.

The most troubling case is Conway. While he has largely avoided taking antipsychotic medication, he has now been detained for over twenty-five years. He has been held primarily in maximum security psychiatric facilities and has had to be forcibly restrained and medicated on numerous occasions. Criminal Review Board records indicate that he responded well to the limited medications that he had received.¹⁸⁵ Aside from these sporadic periods of forced medication, Conway's condition has not improved. Without treatment with the proposed medications, there is little prospect of him being released.

B) Recommendations

In this subsection, we make three recommendations regarding the current *HCCA*. The first addresses treatment delays pending court resolution of patient capacity and the second concerns the lack of safeguards in giving effect to involuntarily detained patients' prior expressed wishes to forgo psychiatric treatment. The third recommendation relates to the absolute priority that the *HCCA* gives to incapable psychiatric patients' prior expressed wishes in all circumstances. Brief reference is also made to how the territories and other provinces have dealt with these and related concerns. Like many features of the current law across Canada, our proposals raise various *Charter* issues. As indicated, however, these matters are best left to detailed analysis on their own merits in subsequent research.

a) Treatment Delays

In our view, precluding treatment initiation pending the CCB's resolution of a challenge to an incapacity finding is appropriate as these proceedings do not entail undue delay. As indicated, the Board is generally required to hold a hearing within seven days and provide a copy of the decision the next day.¹⁸⁶ In contrast, the courts take years to resolve capacity and related issues, leaving untreated psychiatric patients to deteriorate in hospital. Five of the six patients in our study became profoundly disturbed. Four patients required frequent physical or chemical restraint, and prolonged involuntary seclusion. Other serious harms associated with treatment delay include: deterioration in physical health; increased patient suffering; prolonged detention; poorer prognosis; increased assaults on other patients and staff; and disruption of the therapeutic milieu on the ward.¹⁸⁷

¹⁸⁵ *(Re) Conway*, [June 21, 2001] O.R.B at 4.

¹⁸⁶ *HCCA*, *supra* note 10, s. 75(2) and (3).

¹⁸⁷ Gray, Shone and Liddle, *supra* note 7 at 242-47.

We recommend that the *HCCA* should be amended to permit treatment of involuntary psychiatric patients if the CCB confirms the initial incapacity finding. The patient would retain the right to appeal the CCB decision to the courts, but could be treated in the interim. This recommendation appears to be consistent with the current law in several Canadian jurisdictions. For example, in Nova Scotia, and in Newfoundland and Labrador, involuntary psychiatric patients may be treated without their consent pending the outcome of their appeal to the courts, unless a court expressly disallows treatment.¹⁸⁸

b) Safeguards on Prior Expressed Wishes

The current *HCCA* provisions relating to prior capable wishes are problematic. There is considerable controversy about whether capable involuntarily detained patients should be able to refuse treatment that is required to restore their liberty.¹⁸⁹ This controversy is reflected in the different approaches that have been taken across Canada.¹⁹⁰ Even if it is appropriate to defer to a currently competent refusal of an involuntarily detained patient, it does not follow that treatment should be withheld from all incapable patients based on their prior capable wish to reject treatment.¹⁹¹ Hospitalized psychiatric patients who are capable can alter their treatment decisions to reflect their changing circumstances, whereas incapable patients can be trapped by their prior expressed wishes regardless of their current situation or best interests.

Ontario has adopted a very low standard for determining what constitutes a binding prior capable wish. A wish expressed verbally is no less binding than a written directive.¹⁹² Indeed, an informal verbal

¹⁸⁸ *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42, s. 79(4).

¹⁸⁹ This controversy is aptly illustrated by the strong views expressed in both the *Starson* litigation and the outpouring of media coverage that it generated. Indeed, as McLachlin C.J.C. noted in “Medicine and the Law: The Challenges of Mental Illness” (2004 Honourable Mr. Justice Michael O’Byrne/AHFMR Lecture on Law, Medicine and Ethics, delivered at the Universities of Alberta and Calgary, 17 and 18 February online: after 2005) <<http://www.scc-csc.gc.ca/court-cour/ju/spe-dis/bm05-02-17-eng.asp>>, “Views on the decision ... mirrored society’s ambivalence on the issue of treating the mentally ill without consent. Some praised the result. Others deplored it.”

¹⁹⁰ Gray, Shone and Liddle, *supra* note 7 at 201 reported that while eight Canadian jurisdictions “either do not admit capable patients involuntarily or have mechanisms that enable the provision of treatment to an involuntary capable patient, five do not.”

¹⁹¹ Richard O’Reilly, “The Capacity to Execute an Advance Directive for Psychiatric Treatment” (2008) 31 *Int’l J. L. & Psychiatry* 66.

¹⁹² Section 5(2) of the *HCCA*, *supra* note 10, provides that “[w]ishes may be expressed in a power of attorney ... in any written form, orally or in any other manner.”

wish will prevail over an earlier wish expressed in a power of attorney or other formal document.¹⁹³ The wish is binding even if it was not based on an informed or considered view of its clinical or legal significance. There is no requirement for any professional assessment, objective evidence or other proof that the person was capable when the wish was expressed. The *HCCA* simply presumes that the individual was capable when the wish was expressed, unless the contrary can be proven on the balance of probabilities. While assessing a patient's current capacity is relatively simple, retrospectively assessing his or her past capacity is a highly speculative task. Finally, patients do not necessarily have to express any wish. If they previously refused treatment and their capacity was not successfully challenged at that time, this refusal will most likely be treated as a prior capable wish to forgo treatment in any subsequent proceeding.

The current approach to prior expressed treatment wishes stands in sharp contrast to the substantive and evidentiary safeguards that are required to create binding powers of attorney for personal care¹⁹⁴ and advanced directives authorizing the use of force or the waiving of certain legal review rights (Ulysses contracts).¹⁹⁵ Nevertheless, despite the lack of safeguards, prior expressed treatment wishes are binding and largely irrevocable in the case of currently incapable patients. In our view, safeguards should be enacted if individuals are to be given the right to make binding and enduring decisions about their future psychiatric treatment when they become incapable and are involuntarily detained. The wishes should be expressed in a written directive accompanied by a statement from a qualified professional that the individual was competent and informed of the potential health, treatment and legal consequences of forgoing future psychiatric treatment. These recommendations parallel the current Ontario legislation governing advanced directives authorizing the use of force and the waiving of legal review rights.¹⁹⁶

¹⁹³ *Ibid.*, s. 5(3).

¹⁹⁴ *SDA*, *supra* note 25, ss. 46-53. Among other things, powers of attorney must be executed in the presence of two independent witnesses, each of whom is required to sign the document; see *ibid.*, s. 48(1).

¹⁹⁵ Such directives must be made in writing, signed by the grantor, and include a statement from the grantor that he or she understands the effects of the directive. Moreover, the directive must be accompanied by a professional assessment independently confirming the grantor's capacity; see *ibid.*, s. 50(1); and *General*, O. Reg. 26/95, s. 3(5).

¹⁹⁶ *Ibid.*

c) *Balancing Autonomy with Well-being and Liberty*

Except for Ontario, the Northwest Territories and Nunavut,¹⁹⁷ Canada's other jurisdictions have not given absolute priority to the prior capable wishes of involuntarily-detained psychiatric patients. British Columbia provides unrestricted authority to treat involuntary patients against their will,¹⁹⁸ whereas treatment may only be imposed in some other provinces if it is in the patient's best interests.¹⁹⁹ Two jurisdictions permit treatment when it is in the patient's best interests, taking into consideration his or her wishes.²⁰⁰ In Manitoba and Nova Scotia, the patient's prior capable wish must be followed, unless doing so would endanger the patient's physical or mental health, or that of another person.²⁰¹ We recommend that Ontario consider an approach similar to that in Manitoba and Nova Scotia as it best protects the autonomy of involuntary psychiatric patients without endangering their well-being.

5. Conclusion

As *Conway* illustrates, the current Ontario law gives patients virtually endless opportunities to challenge a psychiatrist's or the CCB's finding of treatment incapacity. Years later, even if the courts reject the initial capacity challenge, patients merely have to assert that they had expressed a prior capable wish to refuse treatment to restart the protracted legal proceedings. Should this challenge also fail, patients can then claim that they are now competent to again set the legal wheels in motion. When one factors in claims about substitute decision-makers, the applicability of prior expressed wishes, the impact of prior treatment refusals, and the *Charter*, the legal proceedings can drag on for decades. In the end, profoundly disturbed psychiatric patients are denied effective treatment that leaves them, in the words of one judge,

¹⁹⁷ *Mental Health Act*, R.S.N.W.T. 1988, c. M-10, s.19.4(7)(b). As indicated, Nunavut has adopted the laws of the Northwest Territories; see *Nunavut Act*, S.C. 1993, c. 28, s. 29.

¹⁹⁸ *Mental Health Act*, R.S.B.C. 1996, c. 288, ss. 8 and 31.

¹⁹⁹ See e.g. *Mental Health Act*, R.S.A. 2000, c. M-13, ss. 28(3) and 29(1)-(3); and *Mental Health Act*, R.S.P.E.I. 1988, c. M-6.1, s. 23(9).

²⁰⁰ *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1, ss. 25(2) and (3); and *Mental Health Care and Treatment Act*, S.N.L. 2006, c. M-9.1, ss. 35(1) and (2)(e).

²⁰¹ See respectively, *Mental Health Act*, C.C.S.M. c M110, s. 28(4)(b)(ii) and *Involuntary Psychiatric Treatment Act*, *supra* note 188, s. 39(b). In Quebec, a court must respect an incapable patient's treatment refusal, "unless the care is required by his state of health;" see *Civil Code of Quebec*, Art. 23, para. 2.

“caged and warehoused.”²⁰² Ironically, psychiatric patients who are found unfit to stand trial can be medicated against their will to expedite the criminal proceedings, but not medicated to expedite their recovery and release from hospital.

Three measures are proposed to better protect involuntary psychiatric patients. First, psychiatrists should be authorized to treat involuntary psychiatric patients once the CCB confirms a psychiatrist’s finding of incapacity. Second, prior expressed wishes to forgo psychiatric treatment should only be valid if they are expressed in a signed written directive and accompanied by a qualified professional’s statement that the individual was competent and informed of the directive’s potential health, treatment and legal consequences. Third, a provision should be enacted permitting an involuntary patient’s prior capable wish to be overridden if following it would seriously endanger his or her physical or mental health.

The exact impact of our proposals on the six patients in the current study is difficult to predict. Nevertheless, all six would have been treated either pending the appeal of their finding of incapacity to the courts, or because their prior capable wish lacked the required safeguards or was overridden. Starson, Sevels, Reid, and Gallagher would most likely have been treated and discharged from hospital years earlier. Only two patients over the sixteen-year study period, Neto and Conway, would have been forced to take medications that the courts decided they could refuse. The use of these medications would not have been clinically inappropriate. Indeed, Neto had voluntarily taken these medications for years before being hospitalized and subsequently agreed to take one of them. Conway would have been required to take medications that he has successfully avoided, but as a result of his resistance, he has now been involuntarily detained for over twenty-five years.

In attempting to protect autonomy, the Ontario law has imperilled the physical and mental health of involuntary psychiatric patients and exposed them to indeterminate detention. In our view, a better balance needs to be struck among the competing interests of these patients. In striking this balance, consideration must be given to the impact that the law has on the lives of those it seeks to protect. As our study indicates, treatment delayed results in liberty denied.

²⁰² In *McLachlin*, *supra* note 189, *McLachlin C.J.C.* said, “Hence the cruel paradox – freedom to refuse ‘medication’ may in fact result in institutional confinement and continued debilitation. Is this true autonomy?”

Appendix 1 - List of Search Terms

All of the following were searched under the "same paragraph" option:

Consent capacity board
Consent to treatment
Forced treatment
Unsound mind
Health Care Consent Act 80
Health Care Consent Act 26
Health Care Consent Act 27
Health Care Consent Act 26
Health Care Consent Act 21
Health Care Consent Act 32
Health Care Consent Act Board
Mental Health Act 33
Mental Health Act 34
Mental Health Act 38
Mental Health Act 39
Mental Health Act 48
Mental Health Act 50
Mental Health Act Board
Mental Health Act
Consent Treatment Act