

Informed Consent And Mental Health Legislation: The Canadian Context

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Informed consent is a vital issue in all forms of medicine, especially psychiatry, where patients are often in extremely vulnerable states of mind. Current psychiatric practice involves high risk to patients and the law allows for abrogation of traditional civil rights based on judgments of perceived mental incompetence.

To be valid, consent must satisfy the following criteria:

- a) The person/ patient giving consent must be competent to do so, and competence is assumed unless there is evidence to the contrary.
- b) Consent must be obtained freely, without threats or improper inducements
- c) There should be appropriate and adequate disclosure of information. Information must be provided on the purpose, method, likely duration and expected benefits of the proposed treatment.
- d) Possible pain or discomfort and risks of the proposed treatment, and likely side-effects, should be adequately discussed with the patient.
- e) Choices should be offered, if available, in accordance with good clinical practice; alternative modes of treatment, especially those that are less intrusive, should be discussed and offered to the patient.
- f) Information should be provided in a language and form that is understandable to the patient.
- g) The patient should have the right to refuse or stop treatment.
- h) Consequences of refusing treatment, which may include discharge from the hospital, should be explained to the patient.
- i) The consent should be documented in the patient's medical records¹.

It is useful to note that “anyone who through any element of force accepts a medical treatment or drug has had their rights violated under the Canadian Charter of Rights and Freedoms. Their rights to life, liberty and security of the person have been violated, as well as their rights to equal protection and their rights not to be the subject of cruel and unusual treatment or punishment for refusing or attempting to refuse and unwanted drug or medical treatment...”²

Of course, section one of the Charter has been used in various cases to place “reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.” In other words, the law seeks to strike an appropriate balance between the rights of individuals who suffer from mental health disorders and the role of society in “caring compassionately” for them.

Prior to any discussion of Canadian jurisdictions and the significant differences that exist from one province to another, it is necessary to address the key issues around informed consent. The upcoming discussion of *Fleming v. Reid* and *Starson v. Swayze* highlight neuroleptic drugs.

Neuroleptic Drugs (“medications”)

Researchers who pioneered the use of neuroleptics, i.e. Deniker, Delay, Lehmann and others correctly understood that the drugs achieved their effects not by “normalizing” brain chemistry but by hindering brain function. Precisely how neuroleptics did so started to become clear in 1963. That year, Swedish pharmacologist Arvid Carlsson determined that neuroleptics inhibit dopamine activity.³ At a therapeutic dose, a neuroleptic may occupy 70 to 90 percent of all D₂ receptors.⁴

With the receptors blocked in this way, dopamine cannot reliably deliver its message to cells, and the brain’s communication system is thwarted, and any bundle of nerve fibers that relies primarily on D₂ receptors is sharply impaired. The drugs alter a person’s behaviour and thinking by partially shutting down vital dopaminergic nerve pathways. Once that mechanism of action is understood, it becomes clear why neuroleptics produce symptoms similar to Parkinson’s disease and also why the drugs provide a type of chemical lobotomy. There are three prominent dopaminergic pathways in the brain, disrupted by use of neuroleptic drugs:

- (1) the nigrostriatal system, vital to the initiation and control of motor movement.
- (2) the mesolimbic system, which helps regulate emotion.
- (3) the mesocortical system, vital to the integration of frontal lobe function with other brain regions.⁵

In too many cases, this is a high price to pay for alleviating the symptoms of a mental disorder. Another side-effect known as **akathisia** (internal restlessness or agitation), affects about 25 percent of patients who use neuroleptics. Akathisia has been linked to assaultive, violent behaviour and suicide.^{6,7,8} A closer look at the newer ‘second generation’ neuroleptics shows that pharmaceutical companies are not as transparent as they claim to be.^{9,10,11,12,13,14}

And in the words of a Health Canada sponsored study, “there is no compelling evidence to suggest that mental illness (by itself) causes violence.”¹⁵ Some American studies have argued that at most, 4 percent of all violent incidents have any connection to mental illnesses.¹⁶ At the very least this strongly suggests that public fears are largely misplaced, although they are clearly widespread.¹⁷

Electroconvulsive Therapy (ECT)

At times referred to as electroshock therapy. It has been argued by some that genuine informed consent for electroshock is nonexistent because electroshock psychiatrists deny or minimize its harmful effects. Current theories suggest that the seizure activity induced by electrical stimulation causes changes in brain chemistry. In BC, if a patient is considered incapable, the attending physician should discuss the case, either orally or in writing, with the director of the facility, or his or her designate. That person may sign a substitute consent for an involuntary patient. To be considered ‘capable’ of making a health care decision under the *Mental Health Act*, the patient must demonstrate that he or she appreciates the nature of their condition, the reasons for treatment, and its likely consequences.¹⁸

Psychosurgery

Fortunately, in Canada consent must be obtained from any patient prior to psychosurgery.

The Canadian Context

The key question to ask is whether a particular mental health statute provides for overriding an involuntary patient’s *competent refusal* of proposed psychiatric treatment, in that individual’s best interests. Canadian jurisdictions employ four principal responses to this question:

- (1) A right to refuse treatment (Ontario)
- (2) No right to refuse treatment (B.C., Newfoundland)
- (3) A right to refuse, subject to a “best interests” override (Alberta, Manitoba)
- (4) Excluding treatment competent individuals from committal (Saskatchewan)¹⁹

Due to space limitations, it is best to focus on Ontario and British Columbia. From a civil liberties, or patient’s rights perspective, the case of *Fleming v. Reid* (1990-1) is outstanding as it clearly demonstrates how influential the Charter of Rights and Freedoms is upon provincial mental health legislation. The law, for the most part, is correctly focused on rights rather than needs.

In *Fleming*, the patient had stated, while competent, his wish to refuse the medications which his attending psychiatrist later proposed. The substitute decision-maker, in this instance the province’s Public Trustee, acting under statutory obligation, refused to give consent. The hospital applied to the Review Board to override the refusal, pursuant to a provision in the *Mental Health Act* that obliged the Board to make a treatment decision based on the patient’s best interests. The Ontario Court of Appeal struck this provision down as a violation of “security of the person” in section 7 of the *Charter*. The court found that the statute denied the patient’s right to refuse treatment by making it subject to a best interests test. Moreover, it did so without any hearing into whether the patient’s competent wishes should be honoured, irrespective of what might thought to be in his best interests.²⁰

The result: The objective of state intervention cannot be justified under section 1 of the Charter. Ontario law has since been amended to incorporate the *Fleming* principles. The Consent and Capacity Board has no power to override a competent treatment refusal by an involuntary patient.²¹

The case of *Starson v. Swayze* illustrates how the *Fleming* principles are being applied. Starson had been hospitalized for bipolar affective disorder several times in the preceding 15 years. The court found that Starson understood the information relevant to making a decision about his treatment, including the likely consequences of refusing treatment – i.e, indefinite detention. Although he did not agree with the psychiatrists that he had a mental illness, Starson knew he had mental “problems.” He correctly testified that none of the medications previously prescribed for him had improved his condition, and he objected to their side-effects. In particular, he said that the medications made it impossible for him to work on issues in physics, his one great passion. The Board ruled on what it viewed as being in Starson’s best interests, but that was an improper basis for its decision. The question in law was whether Starson was competent to make the decision to refuse treatment, and the evidence showed that he was. (January 15, 2003)²²

British Columbia

In BC, the director of a psychiatric facility may authorize treatment for patients committed involuntarily, without obtaining consent. Section 31 of the BC *Mental Health Act* states that “treatment authorized by the director is deemed to be given with the consent of the patient.” Further, the *Health Care (Consent) Act*, which essentially codifies the common law on consent to treatment, is expressly stated not to apply to involuntary patients in psychiatric hospitals. And then, sections 7(1)c and 9(1)c of the *Representation Agreement Act* may be overridden by the BC *Mental Health Act*. This leaves involuntary patients and their representatives in a rather vulnerable position. There is no legal guarantee that a patient’s treatment wishes will be respected.

Although involuntary patients have the right to request a second opinion regarding proposed treatment, this does not entail any right to refuse treatment. And the initial treatment plan may or may not be modified. A director “must consider” whether to make changes in psychiatric treatment but need not do so, if the second opinion is deemed inappropriate.

Hopefully, the case of *Fleming v. Reid* will have a positive impact on B.C. mental health law in the near future.

Recommendations

There is no question that, from a patient’s rights perspective, the mental health legislation in Ontario is more advanced than that of British Columbia and other provinces. It appears that the B.C statute is designed to ensure a minimum of procedural delay with involuntary hospital admissions. However, it involves the clearest denial of a right to refuse treatment and may be most vulnerable to a *Charter* challenge on *Fleming*-like grounds. In protecting the rights of profoundly disempowered people, procedural expediency must not take precedence over the

right to competently refuse treatment. A person who is still capable of rational choice should always have the right to refuse treatment even if experts claim that it is “for her/his own good.”

After comparing BC and Ontario mental health statutes, the following is recommended:

- 1.) section 32 (RSBC 1996) Direction and discipline of patients, should be repealed. It is vaguely worded, paternalistic, and places already vulnerable patients into even more vulnerable situations. It states, “Every patient detained under this Act is, during detention, subject to the direction and discipline of the director and the members of the staff of the designated facility authorized for that purpose by the director.”
- 2.) section 34 (RSBC 1996) Notice to involuntary patient, should be amended to include the following: The director (i.e. attending physician) shall also promptly notify a rights advisor and, regarding the contents of notice given to the patient,
 - a.) of the reasons for the detention;
 - b.) that the patient is entitled to a hearing before the Board (Review Panel); and
 - c.) that the patient has right to retain and instruct counsel without delay

and further,

that the rights adviser shall promptly meet with the patient and explain to him or her the significance of the certificate and the right to have it reviewed by the Board (Review Panel).

- 3.) section 36(1) (RSBC 1996) Discharge, which states, “The director may discharge a patient from the designated facility.” should be replaced by section 34(1) (R.S.O. 1990).

As an alternative focus, the Victoria Civil Liberties Association argues against compulsory treatment and for the creation of a better oversight system, which could at the very least, involve:

- 1.) The creation of a psychiatric advocate office. The mandate of such an office would encompass both people who have been institutionalized and people who have not, but who are seeking some sort of help or would seek help if they knew where to turn.
- 2.) A program that would develop registered psychopharmacologists.
- 3.) Improved accountability for professionals working in the mental health field. This would include, at a minimum, the appointment of civilians to the oversight committees in the relevant licensing bodies.²³

Service providers and psychiatrists, in particular, have enormous power to exercise over psychiatric patients. Such power is enormous and has few parallels. If the primary care sector is “calling the shots”, the psychiatrist’s role may increasingly become one of education,

consultation, supervision, research and evaluation, whereby care functions will instead be delegated to primary care workers. Psychiatry needs to collaborate with community organizations, patient and advocacy groups as well as primary health care workers. If psychiatric specialists do not adopt this approach and continue to entrench in their present mode, it is predicted that they will find themselves bypassed as others take over their roles.²⁴

In view of the excessive influence of drug companies upon health and mental health care professionals and even the very determination of what constitutes “illness” and further, the numerous drug side-effects that continue to put vulnerable people at real risk, it is advisable to consider alternatives to neuroleptic drug dependence. “If a proper social environment can be provided, every *newly* identified psychotic deserves several opportunities to recover **without** the use of neuroleptics. The evidence is reasonably clear that the vast majority of *newly* diagnosed psychotics can recover without neuroleptics (Blueyer, 1968; Huber et al., 1980; Mosher & Menn, 1978). The challenge is to organize and present an appropriate intentional social environment.”²⁵

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