

From Duty to Care to Duty to Be Well:
A Discourse Analysis of Ontario's Capacity to Consent Law

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ABSTRACT

From Duty to Care to Duty to Be Well: A Discourse Analysis of Ontario's Capacity to Consent Law

Sheila L. Oakley

Principles of neo-liberalism, our current doctrine of political rationality, call for reduced state involvement and a greater reliance on autonomous, self-governing individuals who avoid risks and take initiatives to improve their well-being. However contradictions arise within these principles. In making autonomous choices, one must also adhere to the values of health and security; individual choice is thereby constrained.

Legal convention upholds the individual right to self-determination with respect to medical treatment. Patients must therefore give their informed consent before medical treatments or procedures are performed. The exception to this rule lies where a person lacks capacity to consent, such as in the case of certain psychiatric patients.

In this thesis I examine Ontario's capacity to consent law specifically as it applies to the capacity to consent to psychiatric treatment. Through a discourse analysis of written legal decisions I argue that successive changes in consent and capacity law, most notably the inclusion of community treatment orders, compel psychiatric patients to align themselves with neo-liberal principles, namely the "duty to be well."

Taking a governmentality approach, I argue that dominant discourses on risk, fear, freedom, autonomy and security inform the legal governance of psychiatric subjects,

compelling these subjects to engage in techniques of “responsibilization” in an effort to reduce various “risks of harm.”

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Table of Contents

Introduction.....	1
Legal Governance of the Psychiatric Subject	5
Thesis Statement:.....	12
Research Arguments:.....	12
Chapter One: The History of Capacity to Consent Law in Ontario: From “duty to care” to “duty to be well”	16
Capacity to consent case law in the North American context	18
Capacity to consent legislation in Ontario:.....	20
The pre-war era: New psy technologies and the “mentally-defective” detainee	22
The post-war era: The medical model and psychiatric dominance.....	23
The “neuroleptic” 60’s – an era of contradictions: Patients rights and dangerousness: Deinstitutionalization and bureaucratization.....	26
The late ‘60s: bureaucracy and dangerousness.....	27
1960s – 1970s: Deinstitutionalization and the emerging “revolving door syndrome”	30
Late 70s - early 80s: From dangerousness to risk: The emergence of consent to treatment legislation.....	31
Defining “mental competency”.....	32
1980s: Post-Charter mental-health legislation	33
The 1990s – Harris’s “commonsense revolution”	36
2000 and beyond: Community treatment orders and the “duty to be well”	39
Current definition of capacity to consent.....	45
Conclusion	46

Chapter Two: Theoretical Approaches to Capacity to Consent.....	48
Power and the psychiatric subject.....	51
The psychiatric subject as a product of power/knowledge	53
Technologies governing psychiatric subjects	56
The affinity of neo-liberalism and legal governance of psychiatric subjects:	58
The role of “risk” discourses in neo-liberal governance.....	59
Approaches to risk	60
“Governing through freedom”	64
From dangerousness to (risk of) dangerousness	66
The “normative” power of law: The intersection of legal and psychiatric discourses	67
Freedom and the intersection of law and psychiatry	69
Chapter Three: Method Principles for the Sociology of Capacity to Consent Law as	
Governance	72
The analysis of discourse:.....	72
The genealogical approach:	75
An analytics of governance:.....	76
Commonsense	77
Hunt and Wickham’s method principles for the sociology of law as governance:	78
An analysis of Ontario’s legal governance of incapable psychiatric patients:	80
A discourse analysis of legal decisions:.....	82
Chapter Four: The Truth Obligation: Insight Into Illness.....	84
Insight and the medical model.....	90
Failure of self-knowledge	92

Failure of self-care	96
The “Catch-22:” “Accepting treatment means I’m ill”	97
Chapter Five: The “Risk(s) of Harm”	101
“Newer and better” medications:	104
Treatment refusal equals incapacity:	105
Risks of treatment non-compliance	108
The “slippery slope” agument: The “risk of future harm”	109
Subverted discourse: Marginalized voices.....	112
Chapter Six:	120
Duty Of Care, Right To Health And The Duty To Be Well	120
The duty of care	123
Induced capacity to consent	125
The “normalizing” process	126
Reducing the “risk of dangerousness”	127
Goals and benefits of CTOs.....	132
Chapter Seven: Concluding Remarks	137
Reference List	147
Appendix A – Cases Analyzed	155
Supreme Court of Canada.....	155
Ontario Court of Appeal	155
Ontario Superior Court/ District Court	155
Community Treatment Orders	157

Introduction

The right to be free from unwanted medical treatment and invasive procedures should not be disregarded lightly.... The consequences of a finding of incapacity are serious. The person found to be incapable loses autonomy over his decision making and, to a large extent, over his person. He may be forcibly treated against his wishes. Our courts have recognized that this constitutes sufficient interference with an individual's personal freedom interests to bring into operation the rights to "life, liberty and security of the person" as guaranteed under s. 7 of the Charter of Rights and Freedoms.¹

The above statement from Justice Malloy of Ontario's Superior Court sets out the significance of being found incapable of consenting to medical treatment: the status of incapable means the subject is no longer free to refuse unwanted medical treatment. For patients involuntarily committed to a psychiatric hospital, this means medication may be administered against their will, by physical force if necessary. Patients found incapable of consenting to treatment who no longer meet the criteria for involuntary admission to a facility may still however be subject to a community treatment order (CTO) under the provisions of Ontario's *Health Care Consent Act*² and *Mental Health Act*.³ In this case, treatment is not administered by physical force, however the subject of the CTO faces the continual threat of apprehension and re-admission should they fail to adhere to treatment appointments or other stipulations of their order. For these patients, "It is not necessary to believe that the individual has caused or suffered any particular harm before police custodial powers may be used to bring the person in for examination" (Hiltz and Szigeti 2004, 273). It is sufficient that a *risk* of harm is perceived by a case worker or attending officer. Similarly, as I will argue based on Ontario's capacity to consent legislation and

¹ *Starson v. Swayze* (1999) 22 Admin L.R. (3d) 211, par. 15

² *Health Care Consent Act, 1996*, R.S.O. 1996, c. 2, Sch. A., as amended.

³ *Mental Health Act, 1990*, R.S.O. 1990, c. M, as amended.

case law, a mere *risk* of harm, either to the self or the public, is often sufficient grounds for making a determination of incapacity to consent.

Justice Malloy's statement also highlights three principal concepts in contemporary society: *freedom, autonomy and security*. In this case, Justice Malloy is referring to security of the *person* against whom forced treatment is applied. However, within the broader context of a risk-averse society, security more frequently refers to security of the *public* from the psychiatric subject. One pertinent example of risk to the public at the hands of a person suffering from a psychiatric illness was the random shooting of Ottawa sports caster Brian Smith by Jeffrey Arenbourg in 1995. Arenbourg had been diagnosed with paranoid psychoses and had been released from the Royal Ottawa Hospital four years earlier, despite being found incapable of consenting to treatment. After much public debate and outcry, this tragic event became the catalyst for Bill 68, *An Act in Memory of Brian Smith, to amend the Mental Health Act and the Health Care Consent Act* (also referred to as "Brian's Law"), the legal instrument introducing community treatment orders.

During the legislative debate on Brian's Law, the Honourable Brad Clark, Progressive Conservative member from Stoney Creek, stated:

Brian's Law reflects our government's strong commitment to balancing individual rights with public safety. We're endeavouring to do that by providing appropriate care and treatment to those who pose a danger to themselves or to others.⁴

⁴ Hansard, OLA, June 5, 2000. Accessed online April 25, 2006. http://www.ontla.on.ca/web/house-proceedings/hansard_search.jsp?searchString=%22Brian%27s+law%22&go=Search&locale=en.

Toronto-based mental health attorneys Hiltz and Szigeti (2004) note that these legislative amendments had the effect of combining dangerousness and treatment capacity criteria. Previously, being found incapable of consenting to treatment was only an issue for patients who also met the criteria for involuntary committal, which was essentially that patients posed a:

1. Risk of serious bodily harm to self;
2. Risk of serious bodily harm to another person; or
3. Risk of serious physical impairment of self (Hiltz and Szigeti 2004, 270).

Following the amendments contained in Bill 68, the following additional criteria were added for involuntary committal:

4. Risk of substantial mental deterioration; and
5. Risk of substantial physical deterioration (Hiltz and Szigeti 2004, 270).

Since involuntary committal criteria were expanded, these changes also expand the category of patients who could potentially be deemed incapable of consenting to treatment.

Being found incapable of consenting to treatment now also affects patients who meet the criteria for Community Treatment Orders under section 33.1 of the *Mental Health Act, 1990*. Additionally, incapacity to consent to treatment was made a condition upon which a patient may be made an involuntarily institutionalized patient under s. 20 (1.1) (e) of the *Mental Health Act*:

- s. 20(1.1): The attending physician shall complete a certificate of involuntary admission or a certificate of renewal if, after examining the patient, he or she is of the opinion that the patient:
[...]

(e) has been found incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained.

The scope of governance over the incapable psychiatric subject is thus expanded allowing for greater surveillance and control over these patients. “Freedom of choice,” I argue, is thereby restrained since the psychiatric subject is seen as unable to responsibly meet the conditions of that freedom; they are not able to care for themselves. This is not surprising given what Hunt and Wickham argue is “a steady advance of legal intervention into ever more spheres of social life” (1994, 70).

In light of this, I argue that Ontario’s laws and legal decisions regarding the determination of capacity to consent to psychiatric treatment highlight competing principles of neo-liberalism: The principles of freedom, autonomy, and security. David Harvey addresses a number of paradoxes of neo-liberal theory. He notes that while this doctrine supposedly champions individual freedom of choice, those choices are greatly limited to those aligned with the goals and strategies of neo-liberalism. Furthermore, this form of regulatory governance “creates the paradox of intense state interventions and government by elites and ‘experts’ in a world where the state is supposed not to be interventionist” (Harvey, 2005, 69). Surveillance and policing are multiplied in an endeavour to restore order and ensure security in a state dealing with the fallout of increasing marginalized populations (Harvey, 2005, 77). Expanding the means by which psychiatric subjects may have psychopharmaceutical treatments imposed upon them is an example of both of these contradictions. These provisions will place greater constraints

upon patients' freedom of self-determination while extending the governance of subjects deemed seriously mentally ill outside of institution walls and into the community.

These principles of freedom, autonomy and security, however, need not be considered at odds. A determination of incapacity to consent to treatment can bring about freedom *through* wellness... freedom from debilitating symptoms and delusional thoughts. In this sense, imposed treatment compliance becomes a strategy aimed at producing a "responsibilized" psychiatric subject; responsible for their own health and security, and, as a consequence, the public's security as well. Through enforced treatment compliance, the incapable psychiatric subject, I argue, is brought in line with the doctrine of the "entrepreneurial subject." As Blackman observed in her study of subjects' voice hearing experiences, "I think we are witnessing the presence of the 'entrepreneurial self,' that is the self who is 'free to choose,' as being one of the key ways in which selfhood is understood" (2000, 56). That understanding, as Rose (1995) points out, is based upon particular assumptions about human agency - the "fiction of the autonomous self." This is an understanding of the self based in knowledges and practices of the "psy" sciences, such as psychiatry and psychology, which purport to authoritatively hold the "truth" about the self. Practices and strategies of governing are then based on this understanding of selfhood (Rose, 1995).

Legal Governance of the Psychiatric Subject

The present thesis examines the legal governance of psychiatric patients and their attempts to resist their incapable status. More specifically, it deals with psychiatric

patients in the province of Ontario who have been deemed incapable and who have applied for a review of their incapacity to consent status. These patients are all either involuntarily committed to a psychiatric facility or are subject to a community treatment order. Either way, they are required to take medication to control their psychiatric condition against their will.

The scope of this study, however, only represents the “tip of the iceberg:”

Historically, less than 10 per cent of applicants have been found capable by the Board on the issue of treatment.[...] Very few of these cases are ultimately heard and determined on appeal to the Superior Court; however, many more appeals are commenced without resolution for extended periods of time (Hiltz and Szigeti, 2004, 162).⁵

As Hiltz and Szigeti have determined, it is very rare, if patients even make an application, for the Consent and Capacity Board, the tribunal representing the patient’s first line of defence, to overturn a physician’s determination of incapacity. And, where a patient loses their case before the Board, very few of those cases ultimately make it to the appeal stage. There is however an importance to examining the texts of these Court and Board proceedings since the language and arguments contained therein provide cogent evidence of the knowledge produced concerning how and why a psychiatric patient is found to be incapable and what implications this has, not only for the patients, but what it says about our contemporary forms of governance in general. Following Hunt and Wickham’s

⁵ In 2005, 1065 CTOs were issued for mentally ill people in Ontario---and they usually called for enforced medication. CBC. The Current. January 23rd, 2006. (<http://www.cbc.ca/thecurrent/2006/200601/20060123.html> Accessed March 15, 2007).

(1994) work on law as a form of governance, I argue that the determination of capacity to consent to treatment is a means of legal governance of the psychiatric subject.

This thesis will explore the discursive production of the incapable psychiatric subject. As Hunt and Wickham point out, the legal and psychiatric professions are examples of “sites of production of knowledge” (Hunt and Wickham, 1994, 13). The decisions rendered by Ontario’s courts of law and the Consent and Capacity Board are evidence of the knowledge produced about the mental capacity of psychiatric patients. Legislation and case law, as Hunt and Wickham argue, are evidence of social strategies (1994, 30).

These texts, in turn, produce more knowledge about psychiatric subjects and inform future strategies. They are relied upon in subsequent legal actions. They are part of the discourse of mental incapacity and as such have very real effects upon those patients and our collective understanding and treatment (in both a general and medical sense) of individuals found to be incapable of forming consent. “Discourses have real effects; they are not just the way that social issues get talked and thought about. They structure the possibility of what gets included and excluded and of what gets done and remains undone” (Hunt and Wickham, 1994, 11).

My interest in the topic of the determination of capacity to consent, and its corollary, the psychiatric subject’s right to refuse treatment, arose following media reports surrounding Scott Starson’s case before the Supreme Court of Canada. After years of court battles before Ontario’s Consent and Capacity Board, Superior Court and Court of Appeal, in 2003 Canada’s Supreme Court upheld the determination that he was capable of

consenting to the psychiatric treatment proposed to him. What this meant was that he retained the right to refuse the administration of the proposed medication. He did, however, remain an involuntary patient in a mental health facility.

I was intrigued with the process by which a subject comes to be declared incapable of consenting to psychiatric treatment and thus loses the freedom to make choices about what procedures and medications will be administered to their body, since this stands in opposition to the principle of freedom viewed as so important to our current neo-liberal political rationalities.

The current definition of capacity to consent in the jurisdiction of Ontario is found at Section 4 (1) of the *Health Care Consent Act, 1996*:

A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

What I sought to research was how this definition actually plays out in an adversarial situation, i.e., before the Board or the Courts. What constitutes an understanding of the information? What information is provided? How are “reasonable foreseeable consequences” considered?

Faden and Beauchamp point out that questions of patient self-determination are a matter of weighing the *risk of harm* versus the possible benefits for the patient or the public (Faden and Beauchamp, 1986). This concept of balancing rights and risks was noted in

the case of *Kirpiev v. Peat*, “this is not an absolute right and requires a balancing process so as to ensure that the right is not lightly disregarded and that any limitations of the right take into consideration the *risk of harm to the patient* and the *risk of harm to the public*.”⁶

It is a balance which must be carefully weighed, however, since “[f]ew medical procedures are more intrusive than the forcible injection of powerful mind-altering drugs which are often accompanied by severe and sometimes irreversible side effects.”⁷

The definition of capacity to consent to psychiatric treatment must be viewed within the context of the social and legal history of informed consent, “competency” and “capacity.” According to Faden and Beauchamp, “[t]he history of informed consent is rooted in multiple disciplines and social contexts, including those of the health professions, law, the social and behavioural sciences, and moral philosophy” (1986, 3). The medical, psychiatric and legal professions as well as the fields of philosophy and psychology have formulated competing and often incompatible perspectives on mental capacity. The concept of informed consent for psychiatric treatment is hence negotiated at the intersection of these disciplines. Carney also argues that the “boundary of competence involves many different disciplines and perspectives because at its base it is a social construct” (1997, 1).

A prime feature of our dismantled welfare state is that health is understood as an individual responsibility. In this context, health risks come to be seen as diseases in and of themselves, to be avoided and cured (Nettleton, 1997). The psychiatric subject thus

⁶ *Kirpiev v. Peat* [2002] O.T.C. 488, par. 31, my emphasis.

⁷ *Fleming v. Reid and Gallagher* (1991) 4 O.R. (3d) 74, par. 75b.

has a duty to avoid health risks by conforming with their proposed treatment as part of what Greco terms the “duty to be well” (1993). These discourses of rights, health, and self-governance come together under the doctrine of neo-liberalism. This current form of governance champions individual freedom, autonomy and rights against state intervention and paternalism (Lupton, 1999, 86). The following statement contained in a position paper on the topic of the capacity to consent to psychiatric treatment, prepared for the Toronto Centre for Addiction and Mental Health, exemplifies this neo-liberal approach:

Individual rights are fundamental and guiding moral and legal principles in modern western democratic society. They have gradually displaced collective rights to assume a primacy unprecedented in history. Foremost amongst individual rights is the right to autonomy and the right to self-determination. For this reason, no treatment in medicine can be given without consent (Skorzewska, 2000, 1).

The exception to this rule of informed consent lies where consent is not forthcoming due to a lack of capacity, most notably as a result of mental illness.⁸ The designation of a subject as incapable of consenting to treatment therefore creates a tension between the obligation of *parens patriae* (insuring care for those who cannot care for themselves), and the neo-liberal ideal of the self-governing subject.

Within this context, social policies seek to reduce perceived social risks by engaging individuals in risk-avoiding behaviours. An example of this is contemporary mental health legislation based on reducing the risk of harm to patients and the public. As Brophy and McDermott point out, in the wake of deinstitutionalization there has been an increasing concern regarding the apparent risks posed by people with mental health problems living in the community. However, “these fears are often exaggerated, a

⁸ *Starson v. Swayze* [2003] S.C.R. 722, par. 7-9.

product of moral panics and media misrepresentations” (2003, S85). In response to these fears, laws governing compulsory community treatment have been introduced as a means of reducing the risk of violence psychiatric patients pose to society while maintaining their stated goal of having patients comply with medication directives in the least restrictive setting. Legislation providing for compulsory treatment in the community, or, community treatment orders, is the latest chapter in the debate over the governance of psychiatric subjects. These orders create are a legal instrument which compel the patient to comply with medication orders (Szigeti, 2001). Furthermore, critics of CTOs argue they are methods of coercion which erode patients’ rights and are a way to circumvent the provision of effective public mental health services while forcing patients to take psychotropic medications, even though they are associated with numerous side effects, including death (O’Reilly, 2004). This poses particular problems since, as Laurance points out, patients may not receive adequate services in the community other than close surveillance regarding their medication consumption. In the U.K., Laurance argues, subsequent to a random killing by a psychiatric patient, the focus of mental health legislation became more concerned with public safety than with patient care (Laurance, 2003).

The underlying assumption informing this paper is that “risks” associated with both mental illness and mental capacity are socially constructed. Taking a social constructionist position means that what is considered a “risk” changes based on the norms, morals and beliefs at work in a given society at a given time (Lupton, 1999, 29). Moreover, risks are constituted within the discourses and knowledge systems surrounding

them. Therefore, the risks associated with mental illness, whether it be how subjects are defined as being “at risk” for mental illness, the risk of harm to the self or others which is associated with mental illness, or the risks and benefits of psychopharmaceutical treatments, are all discursively constituted.

Thesis statement:

The concept of capacity to consent to psychiatric treatment has emerged in accordance with the dominant understandings of mental pathology and autonomy at a given time and place. Capacity to consent is therefore a social construct contingent upon the prevailing legal, political, and psychiatric discourses that serve to negotiate its definition. Our present understanding of capacity to consent, as it is applied in legal decisions, corresponds to the neo-liberal concept of the autonomous, risk-adverse agent. Furthermore, the dominant discourse on capacity to consent to psychiatric treatment has shifted from being informed by a state’s duty to care for those unable to care for themselves to being informed by notions of the entrepreneurial subject’s “duty to be well.”

Research arguments:

I argue that refusal to consent to treatment is itself taken as evidence of “*a failure of the self to take care of itself*” (Greco, 1993, 361, emphasis in the original); a failure of reason that becomes conflated with the incapacity to consent to treatment. While mental health law in Ontario champions the value of autonomy, this conception of autonomy is akin to Rose’s statement that we are not “free to choose but *obliged to be free*” (1998, 17,

emphasis in the original). What gets played out here is the tension between notions of freedom and autonomy on one hand, and the production of intensely governed subjects on the other. By drawing on Foucault's governmentality approach (1991), I show that this legal discourse of autonomy is itself shaped by the prevailing psychiatric discourses constituting the autonomous subject. Psychiatric discourses perform a dual role here since they are at once crucial to the constitution of the self-regulating, risk-adverse agent, while employing a paternalistic approach that aims to normalize the behaviour of the "risky" psychiatric subject and legitimate the enforcement of psychiatric treatment compliance.

I consider capacity to consent law to be an example of "law as governance" (Hunt and Wickham, 1994). It is a technique designed to bring about actions; those actions aim to produce a neo-liberal psychiatric subject: one increasingly made responsible for improving their condition. In order to meet the criteria of the neo-liberal psychiatric subject, one must adhere to a "duty to be well" (Greco, 1993) in following one's prescribed treatment - by force if necessary.

The emergence of consent and capacity provisions in Ontario's mental health legislation will be traced in chapter one. Psychiatric committal and treatment considerations are currently governed by the *Mental Health Act, 1990*, as amended, and the *Health Care Consent Act, 1996*, as amended, respectively. Legislative changes reflect changes in the common-sense understanding of psychiatric subjects and changes in socio-political and

economic doctrine. The emphasis, I argue, moves from the state's duty of care to the subject's duty to be well.

In chapter two I cover the theoretical perspectives informing this research, namely the governmentality perspective and the related genealogical approach. Several pertinent concepts are discussed here: Michel Foucault's work on power, knowledge, modes of objectification and governmentality, the saliency of "risk" and "truth" discourses, Nikolas Rose's contributions regarding the role of the "psy" sciences in constituting our contemporary notion of selfhood, and how our current doctrine of political and economic rationality, neo-liberalism, has emerged alongside and is intertwined with the above concepts.

The third chapter presents the methodology I employ: a discourse analysis of written legal decisions. My reason for choosing Ontario as a jurisdiction is that Canada's leading case on capacity to consent (*Starson v. Swayze*⁹) emerged from this province and because this province has the greatest number of available written judicial decisions on capacity to consent to psychiatric treatment. I explain how this study forms part of a wider analytics of government and why I chose to follow Hunt and Wickham's (1994) method principles for a sociology of law as governance. My analysis of governance explores how knowledge (informed as it is by the "psy" sciences) is used in legal deliberations and, ultimately, in an attempt to reform the conduct of psychiatric subjects, i.e., to bring them in line with the ideal entrepreneurial self. In doing so, my goal is not to pronounce as to the correctness of the decisions taken but rather to provide an alternative prospective

⁹ *Starson v. Swayze* [2003] 304 N.R. 326 (SCC)

– one which examines psycho-legal questions from a sociological social-constructionist position.

In chapters four, five and six I present my analysis of these judgments. I have broken the analysis down in accordance with the three main considerations taken in capacity decisions according to the *Starson v. Swayze* case: 1) the patient's insight into their condition, 2) the evidence of treatment effectiveness, and 3) the goals and consequences of treatment or lack of treatment. The patient's inability to articulate insight into their condition I view as a failure of meeting their "truth" obligation in line with the dominant psychiatric doctrine. This, I argue, is understood as a failure on the part of the patient to show an ability to engage in practices of self-knowledge and self-care. The evidence of treatment effectiveness I argue is also strongly held in line with the dominant psychiatric "brain disease" model (Fabris, 2006). The proposed treatments are presented as highly beneficial in the decisions in contrast to the way patients' concerns with their safety and benefit are downplayed as mere symbols of their "irrationality." Finally, the enunciated goals of treatments will be shown to change over the course of the history of capacity to consent legal challenges.

In chapter seven I will present a conclusion of my findings and suggest directions for futur research.

Chapter One: The History of Capacity to Consent Law in Ontario: From “duty to care” to “duty to be well”

We are presumed to have the capacity to manage our own property, to make our own decisions regarding treatment and disclosure of records, and to live freely where we choose. [...] Once we become sufficiently incapacitated that we or others are at serious risk of harm, the State owes us a duty to protect our interests and that of the community (Hiltz and Szigeti, 2004, 1).

The above statement highlights the delicate balancing act posed by the competing aims of capacity to consent law as a form of mental health governance. On one hand subjects have a right to determine what will be done to their bodies; on the other is the obligation to care for and protect the subject who is unable to care for themselves while also protecting the public. The concepts of “freedom,” “autonomy,” “choice,” “risk of harm,” and “duty to protect” are all challenged by the legislative policy and case law that determines the circumstances under which a subject may be deemed incapable of making treatment decisions. I argue that the contemporary legal history of mental incapacity can be mapped out alongside the emergence of our current neo-liberal form of governing in advanced liberal democracies. The notions of capacity to consent and the right to refuse psychiatric treatment have emerged alongside the production of the neo-liberal subject: one called upon to be a responsible, autonomous, entrepreneurial citizen. Yet, the subject deemed to be mentally incapable is set apart by virtue of (what gets viewed as) their inability to conform to the neo-liberal ideal.

In this chapter I will map out the significant changes in capacity to consent legislation and jurisprudence and situate it within the North American context. While there have also been changes to the criteria by which patients may be involuntarily admitted to

psychiatric wards or independent psychiatric institutions, the focus will be on changes which have a direct impact on the question of whether the psychiatric subject may make their own treatment choices or have treatment forced upon them. I focus on forced treatment rather than forced admittance (or committal) since forcing a patient to undergo treatment strongly compels the psychiatric subject to comply with the neo-liberal “duty to be well.”

Changes in Ontario’s capacity to consent legislation emerged alongside the historical transformation of the concept of mental illness and the role of psychiatric expertise. Mental health professionals gained prestige and legitimacy as the understanding of mental illness shifted from that of a stigmatized condition to a more pervasive malady. These legislative moves also reflect changes in alignment with successive political rationalities, from the paternalism of the welfare state to the autonomous subject of neo-liberalism. In the case of the legal governance of the psychiatric subject, the “freedom to choose” is pitted against the neo-liberal “[tendency] to favour governance by experts and elites” (Harvey, 2005, 66). Policies, legislation, and judicial decisions have increased patient autonomy yet they have also expanded the field of governance by psychiatric experts. With the advent of community treatment orders (CTOs) in 2000, forced treatment now not only affects involuntarily admitted patients but has expanded, in certain cases, to those living in the community as well. Furthermore, as I will argue, the “freedom to choose” where psychiatric treatment is concerned, remains strictly limited to those who show *capacity* for freedom. Capacity for self-discipline and self-care on the

part of the psychiatric subject are the conditions of possibility whereby that freedom to choose may be granted.

Capacity to Consent Case Law in the North American Context

In the U.S., the principle of the right to self-determination by way of protection against physical intrusion by physicians was enshrined by Justice Cordoza in 1914. In the landmark Schloendorff case he stated: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault for which he is liable in damages.”¹⁰ By specifying that persons of “sound mind” possessed a right to self-determination, a division was set up where the same rights and protections were not extended to those of “unsound mind” (James, 2002, 4). This division paved the way for a debate over where the boundary would be drawn as to which persons this right would extend to.

Only in recent decades has there been “a legally defined means for determining competency to give informed consent” (Zapf and Roesch, 2005, 232). The question of obtaining informed consent from an involuntary patient for psychiatric treatment was first tested in a 1979 U.S. federal court case. In *Rogers v. Department of Mental Health*,¹¹ the court ruled that “mental patients have the right to refuse the drugs and seclusion ordered by their physicians on the grounds that patients have a constitutional right to decide what happens to them in reference to psychiatric treatment” (Cockerham, 2000,

¹⁰ *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 105N.E. 92 (1914).

¹¹ *Rogers v. Department of Mental Health*, 478 F. Supp. 1342 (1979).

316). The argument brought by the attorneys for the plaintiffs was that the right to refuse treatment centred upon the risk of potential harm posed by the drugs. Two years later, a U.S. federal appeals court held in *Rennie v. Klein*¹² that persons who are not committed to a mental institution have the right to refuse medication (Cockerham, 2000, 317).

In the Canadian context, a legal definition of informed consent to medical treatment was established as the result of two 1980 Supreme Court of Canada decisions, *Reibl v. Hughes*¹³ and *Hopp v. Lepp*.¹⁴ According to this definition,

1. The consent must relate to the treatment.
2. The consent must be informed.
3. The consent must be given voluntarily.
4. The consent must not be obtained through misrepresentation or fraud (Hoffman, 1997, 8).

From this point forward, physicians had a legal obligation to reveal to patients information “about the nature, expected benefits, and material risks and side effects of the treatment; alternative courses of action; and likely consequences of not having the treatment” (Hoffman, 1997, 8).

Competency to consent was first defined in Ontario legislation under the 1978 *Mental Health Act* as “having the ability to understand the subject matter in respect of which consent is requested and able to appreciate the consequences of giving or withholding consent” (Burra, Kimberley and Miura, 1980, 251). This definition was later interpreted

¹² *Rennie v. Klein*, 653 F.2d 836, 843 (3d Cir. 1981).

¹³ *Reibl v. Hughes* (1980), 114 D.L.R. (3d) 1 S.C.C.

¹⁴ *Hopp v. Lepp* (1980), 112 D.L.R. (3d) 67 S.C.C.

in *Howlett v. Karanaratne* (1988).¹⁵ According to this case, the criteria for mental competency was as follows:

- A person is not “mentally competent” unless that person:
- (1) Has the ability to understand the nature of the illness for which the treatment is proposed;
 - (2) Has the ability to understand the treatment proposed; and
 - (3) Is able to appreciate the consequences of giving or withholding consent (Schneider, 1996, 98).

The patient’s failure to appreciate the existence of their mental illness soon became a key criteria by which competence to consent to treatment was determined, as evidenced by this 1989 Superior Court decision:

The Board’s decision that the appellant was not mentally competent to consent to treatment was confirmed where the appellant denied the existence of her illness, and therefore could not be taken to understand the consequences of giving or withholding consent (Schneider, 1996, 98).¹⁶

Since denial of disorder and, hence, denial of need for treatment, is symptomatic of mental disorder itself according to the *Diagnostic and Statistical Manual of the American Psychiatric Association*,¹⁷ this creates a circular argument by which treatment refusal is taken as evidence of mental incapacity and, hence, a need to enforce treatment (Dellaire et al, 2000).

Capacity to Consent Legislation in Ontario:

The first legislation governing mental health in Ontario was the British County Asylums Act of 1813. That act vested control of mental institutions in the hands of physicians, except for the powers to admit and discharge patients, which were in the hands of the

¹⁵ *Howlett v. Karanaratne* (1988), 64 O.R. (2d) 418 (Dist. Ct).

¹⁶ *McKay v. O’Doherty* (June 1, 1989), Doc. No. Thunder Bay 4768/89 (Ont. Dist. Ct).

¹⁷ For example under DSM-III-R (1987) under “Mood Disorders” it is noted, “Frequently the person does not recognize that he or she is ill and resists all efforts to be treated” (p. 216).

courts (Bay, 2004, 4). Law and psychiatry have therefore been intertwined in the governance of persons with psychiatric disorders in this province since pre-Confederation. In 1850, the first asylum in the province opened in Toronto at the site of what is now the Addiction and Mental Health Services Corporation (previously named the Queen Street Mental Health Centre). Over the course of the following century, the province's psychiatric hospitals "provided treatment, shelter, asylum and custody for the seriously mentally ill, criminals, the homeless and other marginalized members of society."¹⁸ The alignment between mental illness, criminality, homelessness, and marginalization, however, as I will expand upon in my case-law analysis, continues to this day.

Amy James argues that the early history of Ontario's mental health legislation can best be categorized as "unbalanced." Examining mental health law and services for the years 1945 to 1970, she concludes that successive legislative changes "not only reinforced a sense of professionalization and power, but neglected to address issues of competency, consent, and the limitation of the authority of mental health professionals in favour of the patients" (James, 2002, 3). Despite the existence of the Nuremberg Code,¹⁹ both mental health legislation and practitioners continued to ignore or avoid the principle of informed consent. However, as this review of Ontario's mental health policy will suggest, the legal discourse on capacity to consent to treatment paved the way for the extension of informed

¹⁸ Newman, Dan. 1998. *Mental Health: Beyond 2000: Strengthening Ontario's mental health system*. A report on the consultative review of mental health reform in the province of Ontario. Accessed online April 25, 2006. <http://www.health.gov.on.ca/english/public/pub/mental/mentalreform.html>

¹⁹ A set of 10 principles for human experimentation introduced further to the Doctors' Trial of 1947, convicting Nazi war doctors of committing inhumane experimentation. Among the principles contained therein was the necessity of obtaining informed consent in the absence of coercion. Accessed online October 30, 2007. http://en.wikipedia.org/wiki/Nuremberg_Code.

consent rights to mental health patients despite a long history of resistance on the part of psychiatric practitioners.

The Pre-War Era: New Psy Technologies and the “Mentally-Defective” Detainee

The 1930s saw the introduction of the first of a new line of radical treatments being administered in Canada.²⁰ Insulin coma therapy was first used in Toronto in 1937, and was at that time limited to women patients. “Typically, when new treatments were introduced women were selected as the guinea pigs” (Simmons, 1990, 16). This was followed by a brief experiment with Metrazol shock therapy, despite evidence that it caused “compression fractures of the spine” (Simmons, 1990, 18). By 1943 hospitals were directed to cease Metrazol therapy since this treatment would be replaced by newly-purchased electroshock machines. These treatments were administered as a matter of course without seeking consent (Simmons, 1990).

During the 1940s, there was legal uncertainty regarding whether or not electroshock and insulin coma therapy could be administered without a relative’s consent. For lobotomies, however, the law required the written consent either of the patient or of his legally constituted representative since a lobotomy was considered a surgical procedure. Despite this legal requirement, the law also permitted the superintendent of provincial psychiatric hospitals to act as the “committee to the patient” and, as such, “could direct the course of

²⁰ The use of drug treatments in psychiatry had, however, commenced some forty years earlier. In the 1890’s Emil Kraepelin coined term ‘pharmacopsychology’ to describe the new turn to drugs (Healy, 2002, 21)

treatment of the patient” (Simmons, 1990, 213).²¹ Thus, paternalistic powers were routinely exercised, overriding the wishes of both patients and caregivers.

The Mental Hospitals Act of 1935 reflected the social conceptions of mental illness as well as the paternalistic tendency of the pre-war era. “‘Community values’ and the morals of the era dictated to a large extent whether behaviour could be considered within or outside of the norm” (James, 2002, 5). The language and spirit of the law tends to equate mental illness with deviance and criminality. Under this Act, powers to confine the subject to the psychiatric institution are vested with both psychiatrists and law enforcement. “Certification” (or, the declaration of “insanity”) resulted when any two physicians examined a person and certified in writing their conclusion that the person was indeed mentally ill (Bay, 2004, 2). As for the powers of police, the Act stated “[a]ny person apparently mentally ill or mentally defective and conducting himself in a manner which in a normal person would be disorderly, may be apprehended without a warrant by any constable or officer of the peace and detained” (James, 2002, 5). The normalizing power of mental health law in Ontario was thus firmly entrenched.

The Post-War Era: The Medical Model and Psychiatric Dominance

The Post-War era was one in which psychiatry attempted to gain public acceptance and prestige by over-emphasizing the prevalence of mental health problems. Following the 1943 report entitled *Psychiatry Under Health Insurance*, those responsible for mental health policy in Ontario were quoted as saying: “It would probably be fair to say that 50

²¹ Lobotomies were eventually banned with the amendments to the *Mental Health Act* in 1978, nearly twenty years after the introduction of neuroleptic medications (Simmons, 1990).

percent of patients visiting doctors' offices are not exclusively cases of physical illness but have psychological problems as well"²² (cited in Simmons, 1990, 36).

Along with the attempt to further legitimate psychiatric authority came increased paternalism on the part of practitioners and administrators. This was evident in the emerging discourse which linked treatment refusal with mental illness. By the late 1940s, there was clear indication that refusal to consent was considered evidence of the existence of mental illness. In 1948 Dr. Stokes of the Toronto Psychiatric Hospital was quoted as saying "it was quite plain that if a voluntary patient refuses to accept a recognized form of treatment which is recommended, his status as a voluntary patient is open to question" (cited in Simmons, 1990, 25).²³ Treatment refusal was thus associated with being unreasonable – and by association, insane – therefore, upon treatment refusal, a voluntary patient could find herself committed to an institution. This association legitimated the division between reason/non-reason, whereby madness has historically been understood as the absence of reason (Foucault, 1965, ix). Furthermore, the voices of the "sound" mind were legitimated over the voices of the "unsound" (Fabris, 2006).

Not only was paternalism evident in the administration of psychiatric hospitals, but the use of psychiatric treatments as a method of patient control was as well, as this quote from one superintendent suggests:

Our first thought was to give lobotomies to the chronically assaultive, destructive and soiling group of patients that more or less regularly had to be secluded. Our thought was that we probably might not be able to get too many of these patients

²² *Psychiatry Under Health Insurance*, Draft of Report to be made to the Special Committee on Social Security on May 18, 1943.

²³ AO, RG 10, HS 1-2, Box 50, Minutes, Superintendents' Conference, January 23, 1948.

out of hospital, but we would create an easier nursing situation in the hospital (cited in Simmons, 212).²⁴

In keeping with an over-emphasis of the prevalence of mental illness, there was an effort on the part of psychiatrists to have their facilities moved from large, over-crowded provincial mental institutions into wards situated within general hospitals on the premise that their status and salaries would rise accordingly (Simmons, 1990). By 1957 however, their situation had still not changed, with the bulk of funding for mental health remaining in the large institutions. A report published in this year entitled *More for the Mind* by the Tyhust Committee, a group of mental health professionals, was an illustration of the dominance of the medical model in psychiatry at this time. Their “solution was to reveal the truth to the medical and political community, to show them that mental illness was everywhere and that it was the psychiatrist, above all, who was best equipped to deal with it” (Simmons, 1990, 92).²⁵

A series of legislative amendments to the Mental Hospitals Act did however reflect the dominance of psychiatry. In 1952, changes were made to increase the powers of the Superintendent, such that “during confinement, the Superintendent maintained control over one’s custody and care. Treatment, restraint, and examinations all remained subject to the Superintendent’s approval, eliminating the possibility of refusal by a patient” (James, 2002, 5).

²⁴ Archives of Ontario - AO, RG 10, B. 115, Gen. P-2-8-2, December 15, 1958, J.N. Senn, superintendent Ontario Hospital, Hamilton, to Dr. B. McNeel Chief, Mental Health Division.

²⁵ Among other recommendations included in the report were that all aspects of psychiatric services including administration and budgeting be entrusted to psychiatrists, that psychiatric hospital sizes be greatly restricted, that more units be opened in or near general hospitals (Simmons, 1990: 94).

By 1960, the Mental Hospitals Act extended the authority of the Superintendent to “whomever the Superintendent delegated to act in hospital affairs” (James, 2002, 5). Furthermore, it reduced from two to one the number of medical practitioners needed to observe and detain individuals. In the absence of medical practitioners, the Superintendent could simply detain an individual himself. If the person remained detained for thirty days, that patient could then be certified as mentally ill, which could lead to indefinite detention. Furthermore, voluntary patients could no longer discharge themselves, and, even when patients were discharged by the Superintendent, their personal affairs and administration of their estate were placed in the hands of a Public Trustee (James, 2002, 6). These amendments therefore strengthened the authority of psychiatric superintendents, extending their powers over the lives of those determined to be mentally ill.

The “neuroleptic” 60’s – An Era of Contradictions: Patients Rights and Dangerousness: Deinstitutionalization and Bureaucratization

The 1950s and early 60s also saw the emergence of a new class of psychopharmaceuticals – neuroleptics, such as chlorpromazine. Sold under the brand name Thorazine, psychiatric hospitals quickly turned to this as their drug of choice following its release in 1955 (Healy, 2002). It has been argued that changes in legislation brought about in the mid-1960s geared toward extending patient’s rights were partly the result of the advent of these new anti-psychotic medications and the realization that they could carry harmful secondary effects (Bay, 2004, 2; Draper and Dawson, 1990, 285).

The Canadian Mental Health Association's concern with patient's rights has historically been countered by a desire to extend its paternalistic powers. Beginning in 1964, the association produced reports which proposed changes to mental health legislation which were "aimed at achieving two apparently contradictory objectives: to facilitate the apprehension, examination and committal of certain classes of mentally ill people, but also to protect their civil liberties through the establishment of hospital review boards" (Simmons, 1990, 226).

By 1965, legislative changes aimed at strengthening patients' rights began to appear. For example, the 1965 Mental Hospitals Act made it possible for voluntary patients to leave at their will (James, 2002). The 1966 *Mental Health Act* required that inquiries be made into the use of any restraints and the reasons therefore. A review process was also set up whereby designated family or friends could ask for an examination into the need for ongoing detention of an involuntary patient (James, 2002). At this point, however, anyone admitted was also assumed to be incompetent (Draper and Dawson, 1990, 286).

The Late '60s: Bureaucracy and Dangerousness

The late 1960s saw the advent of both the insertion of dangerousness criteria for involuntary committals and the bureaucratization of mental health policy. Changes to the *Mental Health Act* in 1967 and 1968 consolidated several earlier amendments to the legislation and reflected both a changing view of mental illness and an undertaking to extend patients' rights. Changes also reflected concerns with "safety" and "dangerousness." The primary change was one of language – from describing subjects as

“mentally ill” or “mentally defective” to having a “mental disorder.” The aim here was to attempt to remove the stigma associated with mental disorders.²⁶ Before 1967, patients were detained on the premise that their welfare needed protection, whereas under the 1967 *Mental Health Act*, safety became the standard criteria. To be defined as an involuntary patient, the subject had to meet the requirement of being diagnosed with a mental disorder and hospitalization must be necessary “to ensure the safety of the patient or others” (James, 2002, 6). However, changing a patient’s status from voluntary or informal to involuntary was still a matter of simply completing the required paper work. Furthermore, the right of patients to refuse treatment was still without legal support (James, 2002).

The 1967 *Mental Health Act* also ushered in an era of bureaucratization in Ontario’s mental health field. Following the passage of this Act, the number of civil servants working in the mental health bureaucracy increased from a handful of members to nearly 90 (Simmons, 1990, 143). The Act also placed responsibility for mental health policy with the mental health division of the Department of Health. At the same time, the Department of Health “modernized its administrative and accounting system so as to better monitor and control expenditures and management procedures throughout the province” (Simmons, 1990, 43). Non-medical administrators were placed at the head of provincial mental hospitals, assisted by medical directors. As Simmons notes, “[t]he decision to employ generalists who would take a corporate view within ministries led to a

²⁶ Subversive terminology continues to be used to describe persons considered suffering from a ‘mental disorder.’ Reume notes a headline in *The Globe and Mail* from the 1998 inquest into the shooting of Edmund Yu by Toronto police entitled “Mentally ill called ‘loons’ on the job” (2002, 405). Persons with a psychiatric history self-identify as “psychiatric survivor” or “consumer/survivor” (Reume, 2002).

search for bureaucrats with management or administrative training” (Ibid.). Here we find the beginnings of neo-liberal ideals being implemented in mental health policy since there was now an emphasis on accountability and cost-effectiveness associated with mental health care while simultaneously increasing the ranks of administrative expertise.

The insertion of dangerousness criteria in the *Mental Health Act* was first proposed in 1964 but only came into effect in the 1968 *Mental Health Act*. Pursuant to this act, in order to be committed, it would now be necessary to show that “a person is probably mentally ill *and* a danger to himself and others *and* in need of medical attention” (Simmons, 1990, 227, emphasis in original). Persons could now only be committed involuntarily on the basis of both illness and dangerousness to themselves or others. However, in a movement to increase the rights of patients, the Act also established a tribunal to review commitment orders (Bay, 2004). These changes put an end to the procedure of certification and eliminated the possibility of lifetime committal without review.

The 1968 Act also removed the powers of police officers and judges to order detention without a psychiatric evaluation, thus placing some restrictions on legal authority. A psychiatric evaluation was now essential, and, after having previously been increased to a two-physician authorization requirement, involuntary committal now required only the signature of one physician (Ibid.). The result was that committal powers were now placed in the hands of a single psychiatrist. The Act thus in one respect increases

psychiatric authority while at the same time putting in place a series of safeguards by way of a review process.

1960s – 1970s: Deinstitutionalization and the emerging “revolving door syndrome”

The advent of psychopharmaceuticals finally made possible the deinstitutionalization mental health professionals began calling for in the 1950s. The 1964 Royal Commission on Health Services called for the transfer of all patients receiving care from mental hospitals to general hospitals (Wasylenki, Goering and Macnaughton, 1992). As a result, the number of beds in Canadian psychiatric hospitals decreased from 47,633 to 15,011 between 1960 and 1976, while the capacity of general hospitals psychiatric units increased from 844 to 5,836 during the same period (Ibid, 199). These general hospital spots served the needs of less severely ill patients while patients with more severe mental disorders remained in the psychiatric hospitals, thus creating a two-tier system.

However, while the new medications were helpful in reducing or controlling symptoms, there was a lack of adequate community services for those patients being discharged.

The result was the “revolving door syndrome” where these patients would eventually need to be readmitted.²⁷ It would not be until the year 2000, with the introduction of community treatment orders, that a solution would be introduced to this “revolving door syndrome.”

²⁷ Newman, Dan. 1998. Mental Health: Beyond 2000: Strengthening Ontario’s mental health system. A report on the consultative review of mental health reform in the province of Ontario. Accessed online April 25, 2006. <http://www.health.gov.on.ca/english/public/pub/mental/mentalreform.html>

Late 70s - Early 80s: From Dangerousness to Risk: The Emergence of Consent to Treatment Legislation

The next major wave of mental health reform occurred from the late 1970s to the mid-1980s. According to Gilbert Sharpe, a consultant to the Ministry of Health, as late as 1975 doctors still assumed that they had the power to forcibly treat patients against their will and rarely sought consent. When he challenged their treatment procedures he was met with hostility. This led Sharpe to draft a statement of principle for further proposed changes to the *Mental Health Act* stating in effect that physicians “cannot treat patients against their will” (Simmons, 1990, 230). Physicians steadfastly resisted any perceived challenges to their authority and resented the possibility of being referred to a review board before imposing treatment (Simmons, 1990).

Simmons argues that the era commencing in the late 1970s was one of decreasing psychiatric authority and increasing patients’ rights. However, changes to the MHA in 1978 actually expanded the criteria under which a patient could be involuntarily committed. The 1978 *Mental Health Act* altered the committal criteria to allow “committal if a patient suffered from a mental disorder of a nature or quality likely to result in serious bodily harm to the patient or others or imminent and serious physical impairment to the patient” (Bay, 2004, 3). Committal was now based upon the risk of bodily harm or physical impairment rather than the stricter “safety” or “dangerousness” criteria.

The 1978 *Mental Health Act* was part of a movement across North America to reduce civil commitment. However, these legislative changes, along with the majority of other

jurisdictions in the U.S. and Canada, had the opposite effect; civil commitment levels actually increased. “In the five years prior to 1978, involuntary admissions in Ontario fell by 35% but rose by 51% in the subsequent five years, and by 1986/87 had increased 125% above the 1978 level” (Draper and Dawson, 1990, 287). With the introduction of new drugs, many patients were in a position to leave the facilities. However, once they had left, they would fail to follow their treatment, thus the recidivism rate was high (Weisstub, 1990, 319). Jeremy Laurance points to the conclusions of a number of studies in Britain, where a similar trend in increased psychiatric admissions was found. He argued that the increases were more a reflection of the public’s fear of the risk of violence posed by the mentally ill and the mental health care system’s reaction to that fear (2003, 4-6).²⁸

Defining “mental competency”

Another landmark change was that the 1978 *Act* finally defined mental competency: “having the ability to understand the subject matter in respect of which consent is requested and able to appreciate the consequences of giving or withholding consent” (Burra, Kimberley and Miura, 1980, 251). Competency was thus a two-part test, both parts of which must be passed for a patient to be deemed competent to consent to treatment. However, section 12 of the 1978 *Mental Health Act* set out the procedure to override treatment refusals for involuntary patients. Under this legislation, even when determined to be competent to give consent, if consent was not forthcoming, a treatment refusal could be overturned upon a physician’s request before the Board.

²⁸ Data on Canadian involuntary psychiatric admission rates has not been compiled for over 20 years (Crisanti and Love, 2001, 399).

The enactment of a means of defining and determining competency to consent to treatment in the legislation is generally viewed as an advance in patient's rights. However, Burra et al. noted the affront to patients' rights posed by the override provisions.

Presumably the social policy behind this provision is that the involuntary patient should not be allowed to put the public in a position where that patient continues to require hospitalization because of his dangerousness and continues to sap public resources by his refusal to consent to treatment when treatment is available that would render him no longer dangerous (Burra et al., 1980, 252).

Thus, this legislation compelled the dangerous psychiatric patient to treatment as a means of reducing the costs associated with treatment non-compliance. It provided a rationality by which psychiatric patients were to be transformed into responsible, cost-saving, safe citizens. Where a treatment was available, refusing to consent to that treatment was seen as irresponsible, unreasonable and a burden to the public and the mental health care system. The compliant patient is, in other words, considered the "good patient" (Lupton, 1997) and the non-compliant patient is evidently the "bad patient."

1980s: Post-Charter Mental-Health Legislation

The impetus for reform in the 1980s arose from the passage of the *Canadian Charter of Rights and Freedoms*, the emergence of patient advocacy and rights organizations, and public criticisms aimed at the provincial government. By the start of the 1980s, issues such as the lack of affordable housing for former psychiatric patients became a public concern. A series of deaths and reports of mistreatment of mental health patients added

to the outcry.²⁹ Simmons argues that passing a law increasing rights in certain situations was a way to respond to these concerns and criticisms without actually incurring additional financial burdens for the provincial government. It was also “a subtle way for government to reduce the political influence of psychiatrists whose power, like any profession, depends partly on status and prestige” (Simmons, 1990, 235).

Michael Bay, former chairman of the Consent and Capacity Board, points to the resistance shown by psychiatric professionals whenever they perceived legislation was intended to reduce their powers. For example, he notes the 1978 changes to the committal criteria brought proclamations that “the new law tied their hands by only allowing them to commit persons who were of immanent and catastrophic risk to the public” (2004, 5). Furthermore, after the Psychiatric Patient Advocate Office was created in 1983, at first “clinicians and hospital administrators feared and loathed the advocacy office” (ibid.). He speaks of the “mythology” of mental health legislation in Ontario, whereby the media, attorneys, practitioners and the right-wing government, consistently “misunderstand and misrepresent” mental health law provisions. For example, Bay notes, “[r]espected newspapers ran angry editorials under banner headlines demanding the repeal of provisions that did not exist” (2004, 5). The effect was to represent mental health law in Ontario as a risk to a public fearful of the mentally ill and psychiatric patients. The psychiatric subject was thus presented as a risk to public security.

²⁹ In 1981 Ontario established the first Canadian psychiatric patient advocate office in response to a series of deaths which occurred during 1980-81 at the Queen Street Mental Health Centre (Simmons, 1990: 232).

This is not surprising given the tendency of popular media to depict the mentally ill as violent and dangerous (Olstead, 2002). In a discourse analysis of portrayals of mental illness in Canadian newspapers, Olstead found that mental illness was regularly conflated with criminality. Furthermore, his study suggests that this conflation is based on popular notions of agency and responsibility. Mental illness is seen as something which subjects have the ability to control (i.e., by getting better) even while their actions are described as irrational and delusional (2002, 641). The entrepreneurial subject is thus always assumed – even in the face of irrational and delusional behaviour.

A number of changes needed to be made to the *Mental Health Act* in order to bring it in line with the Charter's rights and liberties provisions. Debates over legislative changes centred on the inclusion of override powers for the Review Board. This debate pitted the psychiatric and medical community, who argued for the restoration of the provisions, against psychologists, social workers, mental health advocates and self-help groups, who were opposed to the provisions. The final draft contained an override provision only for those decisions made by the substitute decision maker, and not for those made by competent involuntary patients (Simmons, 1990).

Psychiatric literature commenting on the passage of Bill 7 in 1986 and Bill 190 in 1987, each amending the *Mental Health Act*, highlighted the resistance by psychiatric experts to extending treatment decision freedoms. Psychiatric researchers argued that Bill 7 would lead to an increased number of patients “with potentially treatable disorders” discharging themselves against medical advice (Fernando et al., 1990, 79). Draper and Dawson

argued “[t]he attempt to subject the irrationality of psychotic illness to the due process of rational laws has caused problems” (1990, 285). They go on to state (though without explaining the source of their evidence) that members of the public are “shocked and indignant when they discover that doctors are prohibited by law from treating some persons who are to them obviously disturbed by mental illness” (Ibid.). These comments suggest two things. First, that the law is legitimated as rational while subjugating the irrational knowledge held by the psychotic subject. Second, they uphold the belief in the patient’s duty to be well and the physician’s duty to treat. Laurance would counter that this is indicative of a system run by fear:

Unlike prisoners, [involuntary patients] have been forced to accept treatment, including drugs and ECT, which in any other circumstances would amount to an assault. This is the clearest measure of a system driven by fear – fear of what these people may do to themselves or others (2003, 4).

They are also in keeping with the prevailing assumption, pointed out by Verdun-Jones, that involuntary psychiatric patients are all mentally incompetent (1988).

The 1990s – Harris’s “Commonsense Revolution”

In 1992 the N.D.P. government passed four Acts – *The Consent to Treatment Act, 1992* (from the Ministry of Health), *The Substitute Decisions Act, 1992* (from the Ministry of Citizenship), *The Advocacy Act, 1992* (from the Ministry of the Attorney General), and the *Consent and Capacity Statute Law Amendment Act, 1992*, which repealed the *Mental Incompetency Act* and necessitated amendments to 26 other pieces of legislation, including the *Mental Health Act*. These legislative changes were only proclaimed as of April 1, 1995, just before the N.D.P. lost power in the subsequent election to the Progressive Conservatives. The Harris government then proceeded with a series of what

I will refer to as “roll-back” and “roll-out” legislative changes – corresponding to Peck and Tickel’s periodization of neo-liberalism. The “roll-back” phase refers to the dismantling and deregulation of forms of state welfare while the “roll-out” phase refers to new forms of institutions and regulatory strategies in line with neo-liberal doctrine (Keil, 2002, 580-581). During the “roll-back” phase of legislative changes, the Conservatives immediately repealed *The Advocacy Act*, replaced the *Consent to Treatment Act, 1992* with the *Health Care Consent Act, 1996*, and made further amendments to the related legislation (Hoffman, 1997). Then, beginning in 1995, the Conservative government “rolled out” a series of funding announcements aimed at establishing and enhancing “case management, community treatment teams, and crises response services” (Newman, 1998, online).

The *Health Care Consent Act, 1996*, established the current Consent and Capacity Review Board, before which patients may challenge their incapable status. The Board is invested with the authority to pronounce decisions in disputes between health care professionals, patients, and substitute decision makers, “whether they involve end of life decisions by adult children for an elderly relative or a decision by the parents of a young child to forbid the use of blood products in life and death situations” (Bay, 2004, 5).³⁰

Bay notes that while the Health Care Consent Act has brought about improvements to the degree to which informed consent to treatment is sought, there remains resistance in the psychiatric profession to its implementation.

³⁰ See for example *Sheena B., Re* (1995) 176 N.R. 161 (SCC) for a discussion of religious freedom and blood transfusions.

Many practitioners appear to ignore or misunderstand the rules for consent to treatment. Just as before, if a patient does not resist treatment, he or she is likely to be treated without any consideration being given to the question of capacity. Clinicians, by and large, do not understand that there is no such thing as global competence or incompetence. Many do not understand the presumption of capacity” (Bay, 2004, 8).

Changes between the *Consent to Treatment Act, 1992* and the *Health Care Consent Act, 1996* were designed to “reduce treatment delays” and “strengthen the role of the family,” including making “it easier for family members to assume decision-making authority for loved ones” and removing “barriers for making or using powers of attorney” (Hoffman, 1997, xx). The *Advocacy Act, 1992* was repealed because it was seen as an unnecessary expense, excessively bureaucratic, and symbolic of “the ‘paranoid’ stance of the patient advocacy” (Ibid.).

Hoffman, a mental health law commentator, noted:

The new legislation reflects the expectation of the civil and legal rights in contemporary society as expressed in the *Canadian Charter of Rights and Freedoms*, including freedom and the principles of natural justice, as well as ethical values that should exist in health care, such as respect for each person and individual autonomy. The capable person is given the right to make decisions over his or her life and the incapable person is to be given help to be as independent as possible (1997, xxi).

The principles enshrined in post-Charter mental health legislation are thus aligned with the neo-liberal principles of individual autonomy, independence and the sanctity of the rule of law.

2000 and Beyond: Community Treatment Orders and the “Duty to be Well”

The latest chapter in the history of the concept of capacity to consent to treatment is the community treatment order (CTO), also referred to as compulsory community treatment. Although CTOs were introduced as early as the 1970s in the US, and are now found in some 41 states, in Canada, CTO legislation was first passed in Saskatchewan in 1995 (O’Brien and Farrell, 2005, 27). In Ontario, the introduction of CTOs was noted to be the “single most hotly contested event in the mental health legislative history of this province” (Szigeti, 2001). In the year 2000, amendments were made to Ontario’s mental health laws in line with those in other Western democracies. The most controversial of these changes was the inclusion of CTO provisions, whereby the patient receives supervised compulsory treatment while remaining in the community. The addition of CTO provisions was accompanied by a move to expand “risk-of-harm”-based commitment criteria and to include criteria based on the “need for treatment” (Hiltz and Szigeti, 2004).

The consultation process for these legislative changes began in 1998 when Dan Newman, Parliamentary Secretary to the Minister of Health, was mandated by the Minister of Health, Elizabeth Witmer, to conduct a review of mental health reform. He met with some 89 specified groups, individuals and organizations and received comments from an additional 100 sources. Those consulted included the Coalition of Ontario Psychiatrists, Michael Bay, Chair of the Ontario Review Board, the Chief Coroner, the Ontario Psychological Association, Anita Szigeti of the Mental Health Legal Committee, various mental health services centres, as well as consumer/survivor advocacy groups and self-

help groups. The report based on those consultations, *Mental Health: 2000 and Beyond: Strengthening Ontario's Mental Health System*, made key recommendations for implementing reforms aimed at increasing funding, increasing and improving services, and focusing on “accountability, outcome measures, evidence-based research, and evaluation.”³¹ In terms of legislative amendments, Newman concluded that any new legislation must meet these fundamental principles:

- That legislation supports our government's creation of an integrated and coordinated mental health system capable of providing a continuum of care from prevention to in-hospital and community-based treatment;
- That legislation allows those who need mental health services in Ontario to access those services where and when they need them; and
- That legislation ensures public safety.³²

In April 1999 *Bill 68, An Act in Memory of Brian Smith, to Amend the Mental Health Act and the Health Care Consent Act*, was passed in the Ontario legislature. The legislation, named after Brian Smith, the Ottawa sports broadcaster killed in 1995 by a person suffering from paranoid schizophrenia, came into effect in December 2000. Hiltz and Szigeti (2004) note that the general thrust of the amendments was reflective of a policy shift from dangerousness criteria only to include commitment based on treatment needs as well (252). In addition to introducing community treatment order provisions, involuntary admission was expanded in two key ways. First, the “requirement of imminence” with respect to the “risk of harm” criteria was removed such that it was no

³¹ Newman, Dan. 1998. *Mental Health: Beyond 2000: Strengthening Ontario's mental health system*. A report on the consultative review of mental health reform in the province of Ontario. Accessed online April 25, 2006. <http://www.health.gov.on.ca/english/public/pub/mental/mentalreform.html>

³² Newman, Dan. 1998. *Mental Health: Beyond 2000: Strengthening Ontario's mental health system*. A report on the consultative review of mental health reform in the province of Ontario. Accessed online April 25, 2006. <http://www.health.gov.on.ca/english/public/pub/mental/mentalreform.html>

longer necessary to prove that the patient had previously caused bodily harm to themselves or others (Hiltz and Szigeti, 2004, 268). According to the government's fact sheet on Brian's Law, the word "imminent" was removed "in response to the recommendations of numerous coroner's inquests, health organizations, law enforcement agencies and family groups."³³ The Ontario Medical Association, Ontario Psychiatric Association and the Schizophrenia Society of Ontario called for this change because the term caused "widespread confusion" and "prevented people who needed treatment from getting treatment and has jeopardized both the mentally ill and public safety."³⁴ Secondly, the commitment criteria were expanded to include the risk of mental and physical deterioration as a reason for involuntary admission.³⁵

The end result is that a physician now has five grounds for involuntary committal available:

³³ *Mental Health: Brian's Law (Mental Health Legislative Reform), 2000, The Removal of "Imminent" from Brian's Law*, Ontario Ministry of Health and Long-Term Care, Public Information, Publications. Accessed from the World Wide Web April 25, 2006.

<http://www.health.gov.on.ca/english/public/pub/mental/brianslaw.html>

³⁴ *Mental Health: Brian's Law (Mental Health Legislative Reform), 2000, The Removal of "Imminent" from Brian's Law*, Ontario Ministry of Health and Long-Term Care, Public Information, Publications. Accessed from the World Wide Web April 25, 2006.

<http://www.health.gov.on.ca/english/public/pub/mental/brianslaw.html>

³⁵ The new grounds of committal pursuant to Bill 68 apply to patients incapable of consenting to treatment as contained in s. 20(1.1): The attending physician shall complete a certificate of involuntary admission or a certificate of renewal if, after examining the patient, he or she is of the opinion that the patient:

- a) has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person;
- b) has shown clinical improvement as a result of the treatment;
- c) is suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;
- d) given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or to another person or is likely to suffer mental or physical deterioration or serious physical impairment.;
- e) has been found incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained; and
- f) if not suitable for admission or continuation as an informal or voluntary patient.

1. Risk of serious bodily harm to self;
2. Risk of serious bodily harm to another person;
3. Risk of serious physical impairment of self;
4. Risk of substantial mental deterioration; and
5. Risk of substantial physical deterioration (Hiltz and Szigeti, 2004, 270)

The first three criteria, which were present in the previous legislation, are now referred to as “Box A” criteria. The last two, where the person is deemed to be at risk of substantial mental or physical deterioration if not committed to a mental health care centre, were part of the Brian’s Law amendments in 2000. The new grounds thus add “sickness” criteria to the former “dangerousness” criteria. Government policy documents state the purpose of these changes as such:

The amendments add the ground of “substantial mental or physical deterioration” and focus on harms that could reasonably be expected to arise as a result of a lack of treatment in situations where the person has a history of serious mental disorder that has been successfully treated in the past.³⁶

The patient need not form an imminent and probable danger, nor show signs of impending deterioration, the mere risk of harm stemming from treatment noncompliance is reason enough to compel treatment. Yet, at the same time as this legislation emerged, six of the nine provincial psychiatric hospitals were closed.³⁷ CTOs, I argue, were thus a means of legitimizing the province’s divestment in institutionalized mental health care while placating a public fearful of the untreated mental health patient.

The introduction of the *Mental Health Act*’s section on CTOs sets out their stated purpose, to provide “a person who suffers from a serious mental disorder with a

³⁶ *Mental Health: Brian’s Law (Mental Health Legislative Reform), 2000, New Committal Criteria*, Ontario Ministry of Health and Long-Term Care, Public Information, Publications. Accessed from the World Wide Web April 25, 2006. <http://www.health.gov.on.ca/english/public/pub/mental/brianslaw.html>.

³⁷ Hansard, OLA, June 5, 2000. Accessed online April 25, 2006. http://www.ontla.on.ca/web/house-proceedings/hansard_search.jsp?searchString=%22Brian%27s+law%22&go=Search&locale=en.

comprehensive plan of community-based treatment or care and supervision that is less restrictive than being detained in a psychiatric facility.”³⁸ The intention is to reduce or eliminate an individual’s pattern of improving on medication while in hospital and following discharge deteriorating due to medication non-compliance (the so-called “revolving door syndrome”)” (Hiltz and Szigeti, 2004, 273).

Hiltz and Szigeti have noted that community treatment orders (CTOs) combine the concepts of treatment and detention. The subject of the CTO is required to follow the treatment plan contained therein, under pain of detention. In the case of a CTO the “treatment” is the Community Treatment Plan (CTP) (Hiltz and Szigeti, 2004, 8)³⁹. The CTP is a comprehensive plan that involves supervised treatment (in the form of medication) and the requirement to regularly attend appointments with a psychiatrist or other physician. It may also include other means of surveillance and restrictions on movement, including “participation in daily meetings with members of an assertive community treatment plan (ACT) or living in housing as specified in the CTP” (Hiltz and Szigeti, 2004, 8).

I argue that CTOs are an example of the contradictory nature of neo-liberal regulation: legislation which gives the illusion of freedom while everywhere constraining that freedom. The Consent and Capacity Board has itself alluded to the (contradictory) intents of CTOs:

³⁸ *Mental Health Act, 1990*, R.S.O. c. M, s. 33.1(1).

³⁹ Substitute decision makers are named when a person is found incapable of consenting to treatment in accordance with the *Health Care Consent Act, 1996*.

The provisions of *The Mental Health Act* creating the scheme for community treatment orders are intended to be remedial in nature, not punitive, even though the legislation results in restraints upon the liberties of the people to whom it applies. Community treatment orders were created, according to paragraph 33.1(3), to get patients out of psychiatric facilities and into the community, to be supervised in a less restrictive fashion than in hospitals. Even though a community treatment order does restrain the liberty of a subject, the intent is to reduce restraints.⁴⁰

O'Reilly points out however that the reduced number of psychiatric beds available “has increasingly forced doctors to discharge hospitalized patients, even when many of these patients continue to meet committal criteria. There is, however, no such pressure to end the commitment of patients who are on an outpatient commitment order” (O'Reilly, 2004, 583). O'Brien and Farrell, on the other hand, have found that CTOs are effective in “reducing hospitalization rates and lengths of readmission” (2005, 27). Their study, however, involved only 25 patients in one Ottawa area hospital.

The CTO provides a strategy by which to compel the non-compliant mental health patient to be well. Community treatment orders “compel medication compliance in the community under pain of involuntary psychiatric admission” (Szigeti, 2001, 25-26). The CTO divests the state's traditional, welfarist duty of care for incapable psychiatric subjects who meet the terms of its conditions. Yet it creates new institutions and forms of regulation, which effectively expand the state's means of control, surveillance and supervision. This points to one of the contradictions inherent in neo-liberal ideology – that state interference is not really reduced but is actually expanded. The effect is that the state's duty of care is replaced by the individual's duty to be well.

⁴⁰ *C.I., Re* (2002) CanLII 33965 (ON C.C.B.)

Current definition of capacity to consent

A person is presumed to be capable of consenting to treatment, which includes treatment under a CTO.⁴¹ The current definition of capacity to consent is the same in both the *Health Care Consent Act* and the *Substitute Decisions Act*:

A person is capable with respect to treatment, admission to a care facility, personal assistance services or personal care if the person is able to understand the information that is relevant to making the decision and able to appreciate the reasonable foreseeable consequences of a decision or lack of decision.⁴²

This two-part capacity test is a codification of the principles for assessing capacity developed in the 1990 *Weisstub Inquiry on Mental Competency* (Hiltz and Szigeti, 2004, 149). In addition, the consideration of whether consent has been given is governed by s. 11 of the *Health Care Consent Act*:

11. (1) The following are the elements required for consent to treatment:
 1. The consent must relate to the treatment.
 2. The consent must be informed.
 3. The consent must be given voluntarily.
 4. The consent must not be obtained through misrepresentation or fraud.
- (2) A consent to treatment is informed if, before giving it,
 - (a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and
 - (b) the person received responses to his or her requests for additional information about those matters.
- (3) The matters referred to in subsection (2) are:
 1. The nature of the treatment.
 2. The expected benefits of the treatment.
 3. The material risks of the treatment.
 4. The material side effects of the treatment.
 5. Alternative courses of action.
 6. The likely consequences of not having the treatment.

⁴¹ *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A., s. 4(2).

⁴² *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A., s. 4(1) and *Substitute Decisions Act, 1992*, S.O. 1992, c. 30, s. 45

What gets taken into consideration at the level of the courts, is, as I will discuss in the following chapters, not a simple matter of applying the test for capacity in the legislation. As Chief Justice McLachlin stated in *Starson v. Swayze* (2003), questions of capacity to consent to treatment must balance out three societal values: autonomy, the right to receive effective treatment and security.⁴³

Conclusion

The history of the laws regarding the capacity to consent to treatment in Ontario highlights conflicting principles of neo-liberalism: The principles of autonomy and self-determination and the duty to be well are competing here. Where autonomy rights have been extended to psychiatric subjects in the name of expanding freedom of choice, restrictions have also been placed on that freedom such that freedoms may only be exercised in line with the duties of a responsible health consumer. Where neo-liberal doctrine calls for reduced state intervention, governance of the incapable psychiatric subject has actually multiplied. One strategy employed for expanding the control and surveillance of the psychiatric subject was the expansion of commitment criteria based on a series of potential “risks of harm.” Another was to include treatment incapacity as a new commitment criteria. These changes are a response to public fears over security risks posed by the psychiatric subject.

Throughout this chapter, I have shown that the history of capacity to consent law in Ontario is one of competing claims to authority between law and psychiatry. Psychiatric professionals have continually resisted attempts by legal authorities to constrain the

⁴³ *Starson v. Swayze* [2003] 304 N.R. 326 (SCC), par. 6.

exercise of their powers. In the end, law adopts the discourse of psychiatry as a means of placating public fears through the adoption of CTO legislation.

Chapter Two: Theoretical Approaches to Capacity to Consent

There is no easy answer to the question of when a mentally ill person should be held incapable of making decisions concerning his or her medical treatment. *Different societies have drawn different lines at different times.*⁴⁴

This statement by Chief Justice McLachlin of the Supreme Court of Canada in *Starson v. Swayze* points to the transient, socially and historically contingent nature of the concept of mental capacity. Where to “draw the line” strongly depends upon the ideological position to which one ascribes. The debate surrounding psychiatric patients’ right to refuse treatment has traditionally been polarized between two positions: the “deontological rights position” held primarily by civil libertarians and the “consequentialist position” held primarily by the psychiatric community (Goodwin, 1997, 265).

The deontological position asserts that imposing treatment against a patient’s will goes counter to their civil rights. Proponents of this view suggest that these individuals have the right to be left to make autonomous, independent choices concerning their bodies. They also argue that social policies which aim to restore patient autonomy while minimizing risks through compulsory community treatment are necessarily at odds (Goodwin, 1997, 265).

The psychiatric literature, in contrast, adheres to the consequentialist position and suggests physicians have a duty to treat and that patients have a *right* to be treated. The “right to treatment” argument arose in opposition to the autonomy rights arguments of the

⁴⁴ *Starson v. Swayze* [2003] 304 N.R. 326 (SCC), par. 8, my emphasis.

1970s. According to this theory, “the ‘seriously and persistently mentally ill’ should, by chemical management of their symptoms, recover their reason and conduct themselves accordingly within society; *responsibility confers rights*” (Fabris, 2006, 46-47, my emphasis). Treatment decisions are arguably made in the best interests of the patient. Failure to treat, through the administration of psychotropic medication, is seen as imposing a risk of harm to both patients and public. Consequentialists argue that risk management, by way of compulsory treatment, where the case permits, is a justifiable restriction to patient autonomy (Goodwin, 1997, 265).

A third approach, therapeutic justice, examines questions in terms of whether or not a proposed therapy is beneficial. The approach is most notably used in cases involving substance abusers and the mentally ill in courts of special jurisdiction, such as Drug Courts and Mental Health Courts⁴⁵ (Slovenko, 2004). Bruce Winick, a key therapeutic justice theorist, notes:

It examines the principles of cognitive and social psychology and psychodynamic theory in order to speculate about the likely impact of recognizing that patients and offenders have a right to refuse treatment, and a corresponding opportunity to choose such treatment (Winick, 1994, 100).

The assumption here is that getting a patient to “voluntarily” choose treatment is beneficial, not only because of the treatment itself, but due to the psychological benefits derived simply from exercising “choice” as opposed to being forced to do something.

⁴⁵ CNW Telbec. February 12, 2007. Mental Health Court opens in Ottawa offering hope and better outcomes for those with mental illness. Accessed September 26, 2007. <http://www.newswire.ca/en/releases/archive/February2007/12/c7207.html>

The present thesis breaks with these approaches, all of which are based on traditional liberal principles, by examining capacity to consent law through a genealogical approach – one that examines the conditions that make possible particular strategies vis-à-vis the concept of capacity to consent.

Foucault challenged liberalism's tendency to take dichotomous positions on power as either legitimate or illegitimate. This "juridico-discursive" understanding of power, particularly as applied in law, functions as a means to "delineate the conditions under which the application of state coercion can be justified" (Hunt and Wickham, 1994, 16). Court justices incorporate this liberal doctrine in deciding upon the limitations to subjects' rights to self-determination. The problem with focusing on these dichotomous questions of power, Foucault argues, is that it "deflects attention away from the techniques and tactics of power" (Hunt and Wickham, 1994, 16). My analysis of these legal decisions examines where and how limitations are placed – how administrative tribunals and courts take into consideration psychiatric testimony and come to decisions as to a patient's capacity or incapacity. However, my goal is not to pronounce as to the legitimacy of these decisions but rather to view these decisions as evidence of broader political strategies and techniques of producing entrepreneurial neo-liberal subjects.

In this chapter I discuss the theoretical concepts most compelling for the analysis of these texts. This discussion begins with Foucault's work on power, knowledge and subjectivity as well as technologies of the self as these concepts are fundamental to an understanding of how the incapacitated psychiatric subject is produced and regulated. I situate the

analysis within our contemporary form of socio-political rule, neo-liberalism. The move to neo-liberalism over the past three decades has produced the neo-liberal subject (Isin, 2004, 217); an entrepreneurial subject responsible for their own welfare. Neo-liberal governance strategies accordingly operate on presumptions of autonomy and self-discipline. This is essential to understanding how capacity to consent law, including the emergence of community treatment orders, problematizes and responds to treatment non-compliance.

I also discuss the governmentality approach to risk and its appropriateness to the study of capacity to consent. I argue that treatment non-compliance is constituted as a “risk object” and contemporary capacity to consent laws are strategies aimed at regulating that risk. A number of contradictions inherent in neo-liberal ideology become apparent. As risks become generalized and discursively multiply, greater interventions of surveillance and control are employed, thus contradicting the doctrine of reduced state intervention. Furthermore, while neo-liberalism assumes a free and autonomous subject, governance strategies constrain self-determination and the choices one is “free” to make.

Power and the Psychiatric Subject

Power, in the Foucauldian sense, operates on the local, everyday level. As Turner points out, “[p]ower is embodied in the day-to-day practices of the medical profession within the clinic, through the activities of social workers, through the mundane decision-making of legal officers ...” (1997, xii). These are typical examples of the way power is exercised in the day-to-day lives of persons who are subject to determinations of capacity

to consent to psychiatric treatment. Relations of power/knowledge are at work within the context of the psychiatric assessment, the social workers involved in the individual's community treatment plan team, and the decision-making processes of police officers, Consent and Capacity Board members and Court justices.

Power can be exercised to produce knowledge about subjects and knowledge in turn is implemented in the exercise of power. Power and knowledge are thus inextricably intertwined. Foucault notes, "there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations" (Foucault, 1984, 175). This concept of power is not negative and coercive but rather it is *productive* in that it produces a particular type of subject. The exercise of power is "a way in which certain actions modify others" or "an action upon an action" (Foucault, 1982, 219-220). This form of power operates through techniques of persuasion aimed at modifying practices (Foucault, 1991).

In contrast, acts directly aimed at a body are acts of violence, not acts of power, whereas those aimed at the soul or the psyche work in a positive sense to produce certain actions (Foucault, 1984, 173; 176). There are, however, instances where acts of violence continue to be used. An example lies in the forced medication of psychiatric subjects deemed incapable of consenting to treatment. In some instances, this results in both the physical and chemical restraint of the subject.

Power only exists when it is exercised; it is therefore not possessed or exchanged. The possibility of resistance is always present since “power is only effective if the subjects of power are able to react in a range of ways” (Nettleton, 1997, 217). This implies that subjects must be free to act. This poses a quandary, however, in the present study since the psychiatric subject’s freedom to act is constrained both by the symptoms of their condition and by the legal restrictions placed upon their freedom.

The analysis of power relations lies in the examination of the resistance to forms or techniques of exercising power. This may include, for example, struggles against techniques of social domination or exploitation (Foucault, 1982, 211-212). It may also include resistance to various forms of knowledge and claims to “truth,” such as those proclaimed by medical or psychological experts. In the cases before us, I examine the incapacitated subjects’ resistance to their status and truth claims regarding their condition.

The Psychiatric Subject as a Product of Power/Knowledge

Foucault⁴⁶ argues there are three modes of human objectification. These modes function to turn human beings into subjects of knowledge. The first refers to methods used in the

⁴⁶ In *Madness and Civilization* (1965), Foucault traced the genealogy of the point where madness was constituted as a mental illness. The point was argued to lie at the end of the eighteenth century when the language of psychiatry ended any further debate as to what madness was - “it was mental illness” (x). The publication of this treatise coincided with the emergence of the anti-psychiatry movement of the mid 1960s (Turner, 1997, x). Key players in this movement, namely Thomas Szasz and R.D. Laing, went so far as to claim that “mental illness did not exist, and that the treatment being used for mental illness were simply chemical straitjackets” (Healy, 2004, 219). While these claims may fall at the extreme end of a critical continuum, they form part of the critique of disease categories as forms of social normalization. This critical approach to the understanding of mental illness was part of the shift from medical sociology to the sociology of health and illness, a movement informed by Foucault’s theoretical and philosophical analysis (Turner 1997).

pursuit of scientific inquiry whereby subjects are objectified, for example those used on prisoners or patients. The second consists of “dividing practices;” ways in which subjects are characterized as, for example, healthy or sick, sane or insane. Lastly, humans are *subjectified* when they engage in turning themselves into subjects (Foucault, 1982, 208; Rabinow, 1984, 8-10).

Since the subject is an object of knowledge, and the scientific realm of knowledge within which the modern subject has arisen is concerned primarily with a search for the “truth,” the modern subject is tied to an obligation of truth. This truth obligation is at once an obligation to know the truth about oneself and to confess that truth to others (Foucault, 1997). While the process of subjectification involves measures taken by people to create themselves and to know themselves as particular types of selves, these measures are mediated by authority figures. In this case, the authority figures are experts who uphold various forms of knowledge as the “truth.”

The contemporary form of scientific inquiry governing the incapacitated psychiatric patient is psychiatry, and the related discipline of psychology as well as social work. The birth of psychiatry and psychology as scientific disciplines made it possible to develop knowledge in keeping with a particular brand of truth, and the practitioners of this new discipline claim authority to this truth (Rose, 1998, 22).

Within the field of medicine, and psychiatry more specifically, the disease model of illness is the current medical framework by which psychiatric conditions are understood.

Medical frameworks are ideologies that uphold certain ways of knowing about conditions while subverting other explanatory models (Eaton, 2001, 9). The introduction of psychoactive drugs represents the genesis of a *new* medical model while signalling the end of the age of psychoanalysis, mainly the Freudian psychoanalytic approach (Cockerham, 24). Bassman has observed that since the dominant position on mental illness is the “brain-disease model,” only chemical solutions are proposed to improve subjects’ lives (Bassman, 2005, 490). Since the dominant position is upheld as the “truth,” alternative solutions are problematized.

Dividing practices are methods by which “the subject is objectified by a process of division either within himself or from others” (Foucault, 1982, 208). These practices are therefore closely linked to the scientific (or pseudo-scientific) modes of inquiry by which those subjects are understood, classified, and worked upon (Rabinow, 1984, 8). In the context of my analysis, they are practices, informed by dominant legal and psychiatric discourses, by which the subject is declared capable or incapable of consenting to treatment.

Acts of subjectification are ways in which people engage in “self-formation” (Rabinow, 1984, 11). Practices of subjectification therefore require that a person be free to act. Rose defines subjectification as “processes and practices by means of which human beings come to relate to themselves and others as subjects of a certain type” (1998, 25). In other words, they are methods by which we come to know ourselves. We may know ourselves as confident, unstable, determined, stressed, or belonging to any variety of

categories. As we will see from the cases being analyzed, it is hoped that through treatment compliance, by force if necessary, incapable psychiatric subjects will improve their conditions to the point at which they may gain insight into themselves and, thus, be able to achieve the ability to form self-knowledge. That self-knowledge, however, must correspond to certain dominantly held scientific “truths.” As Foucault argued, the “main point is not to accept this knowledge at face value but to analyze these so-called sciences as very specific “truth games” related to specific techniques that human beings use to understand themselves” (1997, 224). Through the present thesis I hope to challenge certain “truth games” related to the techniques imposed upon psychiatric subjects.

Technologies Governing Psychiatric Subjects

Two other concepts instrumental to the analysis of capacity to consent case law are “technologies of the self” and “technologies of power.” Both, I argue, are employed in the legal governance of the incapable psychiatric subject. Technologies of the self are “technologies which permit individuals to effect by their own means, or with the help of others, a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality” (Foucault, 1997, 225).

These practices are forms of self-discipline but should not be considered entirely self-directed but rather as techniques informed by experts of the “psy sciences” (Rose, 1999a). Rose notes that this shift from discipline to self-discipline occurred alongside the emergence of the psychological professions (Rose, 1999a). These professions therefore

played a vital role in defining both the concept of the self-disciplining neo-liberal subject and the practices people were to employ in order to emerge as a self-disciplined subject.

Technologies of power are those “which determine the conduct of individuals and submit them to certain ends or domination, an objectivizing of the subject” (Foucault, 1997, 225). Compelling mental health patients to comply to treatment requires both of these forms – technologies of power to impose treatment, and technologies of the self to bring about a state of self-compliance with treatment and the duty to be well. Self-mastery is, however, a prerequisite for obtaining a satisfactory level of mental health. If the patient cannot show that she is capable of mastering her impulses and eliminating her delusions, then she will continue to be ordered to work upon improving her mental health through enforced treatment compliance.

Greco explains this failure of self-mastery as a failure of self-care: “If the regulation of life-style, the modification of risky behaviour and the transformation of unhealthy attitudes prove impossible through sheer strength of will, this constitutes, at least in part, a *failure of the self to take care of itself* – a form of irrationality, or simply a lack of *skillfulness* [...]” (Greco, 1993, 361). Self-care is a prerequisite to being an active, productive citizen in a neo-liberal society. One must master self-care by means of self-discipline or one will be forced to do so.

The Affinity of Neo-liberalism and Legal Governance of Psychiatric Subjects:

I argue that the legal governance of psychiatric subjects has changed from the state's duty of care to the patient's duty to be well. This change, I argue, has emerged alongside the move from liberal to neo-liberal rationalities. Our contemporary form of governance "is characterized by an approach to political rule, neo-liberalism, which champions individual freedom and rights against the excessive intervention of the state" (Lupton, 1999, 86). It also calls upon citizens to make their own choices and provide for their own welfare (Lupton, 1999, 25).

According to neo-liberal theory individual freedoms are guaranteed through "strong individual property rights, the rule of law, and the institutions of freely functioning markets and free trade" (Harvey, 2005, 64). While the state preserves the freedom of the marketplace, individuals are called upon to be accountable for their own well-being through responsible actions. Success or failure, whether in terms of finance, education, health, or other aspects of one's life, is attributed to the individual's entrepreneurial strengths and weaknesses (Harvey, 2005, 64-65). Strategies aimed at governing the subject of freedom are contingent upon the wider economic and political perspective, one that argues for the removal of barriers to the freedom of choice (Rose, 1999b, 84). As a mode of discourse it has become so pervasive as to become "the common-sense way many of us interpret, live in, and understand the world" (Harvey, 2005, 3).

Neo-liberal rationalities emphasize "the entrepreneurial individual, endowed with freedom and autonomy, and the capacity to care for him- or herself" (Rose, 1993, 288 in

Petersen, 1997, 194). Individuals are attributed “social destinies” according to their capacity for both self-care and risk avoidance (Petersen, 1999, 193-194). The social destiny attributed to psychiatric patients who fail at self-care and risk avoidance is that of being labelled incapable of consenting to the treatment proposed by the psychiatric experts. After all, “freedom must be practiced ethically” (Foucault, 1997, 284) and, if the patient is unable to do so, certain restrictions will be imposed on their autonomy.

The principle of “responsibilization” is an important feature of neo-liberal doctrine (Dean, 1999, 166). And a neo-liberal health system is one that produces responsible health entrepreneurs (Osborne, 1997; Rose, 2000). Psychiatric patients, I argue, are no exception to the entrepreneurial rule – only for them, responsibilization means adherence to the “psy expert’s” chosen course of treatment. The patient is thus responsible for adhering to a “duty to be well” – the duty to reduce the risks associated with treatment non-compliance.

The Role of “Risk” Discourses in Neo-Liberal Governance

How do deregulated and divested institutions, such as the deinstitutionalized mental health services, operate as sites of power/knowledge production in the context of a neo-liberal society? How do they produce responsible mental health entrepreneurs? Turner argues that our current uncertainties at the level of the global political economy and the associated global risks have created a desire for greater surveillance and discipline within our internal social structures. “[A] risk society, based on deregulation and devolution, often requires more subtle and systematic forms of control” (Turner, 1997, xviii). In the

area of health and medicine, an increased focus on generalized risk results in greater emphasis on surveillance and prevention, such that risks come to be worked on as diseases in and of themselves – to be eliminated (Lupton, 1995; Turner, 1997).

Therefore, where a psychiatric subject is argued to pose a risk of harm to themselves or others without proper medication, whether or not there is any substantiated evidence of harm inflicted, restrictions are imposed on their autonomy in an effort to avoid potential harm. But as risks are discursively generalized and expanded so too are the strategies employed to counter those risks.

Approaches to Risk

Theoretical approaches to risk fall into two broad camps: the psychometric perspective and the social constructionist perspective. Psychometric approaches to risk are based on a theory of rational behaviour by rational risk-adverse agents (Lupton, 1999, 21). This perspective holds that risks are understood as objective facts whereby expert knowledges hold the “truth” concerning the probabilistic nature of risk occurrence. Individuals are then judged on their ability to self-regulate their behaviour in accordance with these expert accounts (Lupton, 1999, 18-19). In contrast, social constructionist perspectives examine the way risks are understood and constituted within the broader social and cultural setting (Lupton, 1999, 18, 25).

An underlying assumption informing this thesis is that the concept of mental incapacity and the risks associated with it are socially constructed. Taking a social constructionist position means that what is considered a “risk” changes based on the norms, morals and

beliefs at work in a given society at a given time (Lupton, 1999, 29). Furthermore, risks are constituted by the discourses and knowledge systems surrounding them. Therefore, the risks associated with mental illness, whether it be how subjects are defined as being at risk of harm to self or others, or the risks and benefits of psychopharmaceutical treatments, are all discursively constituted.

Risk discourses are technologies of governance that operate through the exercise of power and knowledge. In keeping with Foucault's analysis of bio-power, technologies of risk are both individualizing and totalizing; they work on the conduct of individual lives as well as the whole of the social body (Petersen, 1997, 194). The risk discourse goes beyond mere dichotomies of healthy or unhealthy, sane or insane, to include a whole range of behaviours deemed to be potentially "at risk" (Petersen, 1997, 195).

Furthermore, strategies aimed at preventing risks have regulatory effects upon those individuals deemed to be "at risk" (Petersen 1997, 193). In this case, psychiatric patients found incapable of consenting to treatment have their treatment, living conditions and daily routines regulated as a means of countering the risks associated with their illness.

The word "risk" is associated with a wide range of phenomena in contemporary society. But how do issues get framed as "risky?" To be deemed risky, Lupton argues, behaviours and substances must first become constructed as "risk objects." This has the effect of identifying those objects as the source of harm (Lupton, 1999, 30-31). In our neo-liberal environment, risks are understood as calculable events to be managed by rational social actors. Risk is therefore associated with individual choice and autonomy, with blame

being placed on those who make risky choices. In Ontario's consent and capacity case law, treatment non-compliance is, I argue, clearly identified as a risk object. As the consent and capacity judgments indicate, treatment non-compliance is associated with a variety of risks, such as the risk of deterioration of mental condition and a neglect of self-care. These two situations are, in turn, argued to lead to behaviour dangerous to the individual and to the public.

The approach I take to risk discourse is based on the governmentality approach inspired by Michel Foucault.

Taking a governmentality approach to risk means exploring how the concept of risk is produced in a society where the population is surveilled and regulated in a subtle and insidious manner; where citizens engage in their own surveillance and regulation. Concepts of risk that arise in this environment arguably produce particularly normalized behaviour, which citizens are expected to adhere to (Lupton, 1999, 25).

The governmentality approach to risk stems from Foucault's 1978 lecture of the same name wherein he explained the necessity of studying technologies of power in concert with an analysis of their corresponding political rationalities (Lemke, 2000: 1). Here Foucault shows that, beginning with the population expansion in the eighteenth century, the affairs of government turned to the problems of the population as a whole. From this point on, government concerns extend beyond the mere "act of government" to include goals of health, welfare, and prosperity (1991, 100). The power exercised by government becomes positive, in the sense that the goal is overall improvement and productivity. These ends can be achieved both by direct and indirect means, through strategies which persuade members of the population to engage in practices which lead to desirable ends

(ibid). This thesis examines the strategies used to persuade psychiatric subjects, the practices to which they are persuaded to adhere and the ultimate goals of those practices as detailed in the capacity to consent case law.

To govern, Foucault argues, “is to structure the possible field of action of others” (1982, 221). Governance therefore presupposes freely acting subjects: “subjects who are free in the primary sense of living and thinking beings endowed with bodily and mental capacities (cf Patton, 1998)” (Dean, 1999, 13). This has important implications for the study of the governance of psychiatric subjects, particularly where the status of their mental capacity is the object of a legal challenge. But as Dean acknowledges, even where freedoms are removed, such as being imprisoned, the subject “is urged to take responsibility for her own state, and the pain she is causing herself, and to take such action as will remove that pain” (1999, 15). Similarly, I argue that the involuntary psychiatric patient, or the subject of a community treatment order, is encouraged to act responsibly by agreeing to and adhering to a treatment plan.

According to Dean, government works both through practices of freedom and practices of domination (1999, 34). To govern is to recognize the subject’s capacity for action. In situations where tactics of “coercion, constraint, domination and oppression” still operate, freedoms are constrained. Justifications for those constraints are often given on the basis of upholding the freedom of others. Rose notes that this argument of the constraint of the few for the freedom of many is then made to justify coercion with the aim of reforming

“pathological individuals so that they are willing and able to accept the rights and responsibilities of freedom” (Rose, 1999b, 10).

“Governing Through Freedom”

As previously discussed, our present technologies of government are geared towards governing through freedom, however, a paradox arises here: the “opposition between freedom and government:”

Freedom is understood in terms of the act of liberation from bondage or slavery, the condition of existence in liberty, the right of the individual to act in any desired way without restraint, the power to do as one likes. The politics of our present, to the extent that it is defined and delimited by the values of liberalism, is structured by the opposition between freedom and government. (Rose, 1999b, 62)

To the extent that a subject is governed, then, freedom is constrained. Rose argues there is a particular type of freedom that has an affinity with the current means of political rule (1999b, 63). Our current idea of freedom is one infused with the notion of an autonomous individual exercising free choice. That freedom of choice must, however, be exercised responsibly; this is a condition placed on freedom. “Individuals, that is to say, must come to recognize and act upon themselves as both free and responsible, both beings of liberty and members of society, if liberal government is to be possible” (Rose, 1999b, 68). Of course, a mode of government which endows the subject with the requirement to choose responsibly, also gives them the right to *refuse* responsible choices (ibid.). And that is the case of psychiatric patients refusing treatment and challenging their status as “incapable” of making a (responsible) choice.

Various strategies are employed with the aim of persuading “at risk” subjects to exercise their freedom responsibly. Rose gives as an example the new risk-management strategies which have come to “shape the provision of mental health services across the English-speaking world in the late 1990s” (1999b, 4). I argue that changes brought about to Ontario’s capacity to consent laws in the same time period are also a response to the risk-management discourse directly aligned with neo-liberal ideology.

Harvey also argues that while “individuals are supposedly free to choose” (2005, 69), those choices are greatly limited to choices which are aligned with the goals and strategies of neo-liberalism. Furthermore, certain individuals remain excluded from the neo-liberal regime of choice – by virtue of their lack of freedom. These individuals are the “usual suspects” – single parents, juvenile delinquents, substance abusers, and the homeless. Most importantly for our purposes, these individuals also include former involuntary psychiatric patients (Rose, 1999b, 88-89). Neo-liberal governance also “creates the paradox of intense state interventions and government by elites and ‘experts’ in a world where the state is supposed not to be interventionist” (Harvey, 2005, 69). Surveillance and policing are multiplied in an endeavour to restore order and ensure security in a state dealing with the fallout of increasing marginalized populations (Harvey, 2005, 77). Deinstitutionalization has arguably increased the population of the mentally ill, a marginalized population, on the streets. Strategies aimed at restoring order and security include enacting new legislation such as the Safe Streets Act, which effectively criminalizes homelessness and panhandling, and Brian’s Law, which

mandates the conditions whereby deinstitutionalized mental health patients would not be returned to the community unless their condition is chemically controlled.

From Dangerousness to (Risk of) Dangerousness

According to Rose, the move from thinking in terms of pathologizing subjects to constructing individuals as “at risk” creates an extended role for “psy” experts. It is now necessary to observe, note and assess factors that can be used to “predict future pathology.” In the governance of risk, not only do these experts claim to be able to predict future behaviour but they are increasingly obliged to make probability calculations, based on a combination of risk factors, that accurately assess an individual’s propensity to pathological behaviour (Castel, 1991, 281; Rose, 1998, 94-95).

The result of this move is that indications of dangerousness no longer have to be personally observed. “It is enough that she or he is identified as a member of a ‘risky population’ based on a ‘risk profile’ developed from calculations using demographic and other characteristics” (Lupton, 1999, 93). This is further based in the belief that the actions of individuals are highly predictable (Lupton, 1999, 94-95).

The problem with both the “dangerousness” and “risk of dangerousness” theories promoted in the psychiatric field is that, either way, mental illness becomes conflated with dangerousness. This problem is further aggravated when one considers that the “diagnosis of mental illness lacks reliability, and psychiatry is generally unable to predict dangerousness with any great precision” (McCallum, 1997, 46). It has also been noted

that changes to the *Diagnostic and Statistical Manual (DSM)* further attempt to conflate dangerousness and mental illness – “the official definitions of pathology used by psychiatry, as contained in the various versions of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, have increasingly, with each new revision, incorporated language about ‘violence’” (Dellaire, 2000, 683). The end result is that a set of tautological criteria is applied – “need for help, need for treatment, lack of compliance, lack of insight, inability to take care of oneself” (Dellaire, 2000, 691-692). This can lead to legal intervention (the need to control) to impose psychiatric “help” (the need to treat) – an intersecting of legal and psychiatric discourses.

The “Normative” Power of Law: The Intersection of Legal and Psychiatric Discourses

Beginning in the nineteenth century, legal practitioners turned to the disciplines of medicine, psychiatry and social sciences to aid in their deliberations. Foucault refers to this as the “normalization” of the law (Rabinow, 1994, 21). Given that the twentieth century has been referred to as the “Age of Psychiatry,” questions of human behaviour have been spoken about in the language of psychiatry. Since the law also makes pronouncements on human behaviour, it too refers to the language and principles of psychiatry. Law, in turn, also regulates psychiatric practices: questions of institutionalization, right to treatment, and right to refuse treatment amongst them (Slovenko, 2004). Questions of capacity to consent to treatment, including the capacity to consent to treatment orders, necessarily involve the intersected discourses of law and psychiatry.

In contrast to the popular notion of the legitimacy and neutrality of law, Carol Smart argues that “law exercises power” and that the exercise of that power needs to be challenged (Smart, 1989, 4). Foucault observes that some discourses, such as expert discourses pertaining to law or medicine or psychiatry, make claims to truth that become legitimated by a society which holds expert knowledges as the ultimate truth. According to Smart, law sets itself at the top of this hierarchy, even above other forms of expert knowledge, while at the same time disqualifying competing forms of knowledge (1989, 10-11). The “truth” upheld by law should therefore be investigated rather than taken for granted (Hunt and Wickham, 1994, 12). Law “also involves a distinctive production of truth. Not only do procedures of law (trial, cross-examination, etc.) provide authorized means by which the truth is discovered, but once enunciated law provides the guarantee of this truth” (Hunt and Wickham, 1994, 41).

Judgments determining what is in a person’s “best interests” may therefore sound objective when expressed in authoritative terms by courts of law. The belief that law is neutral and relies on scientifically determined objective facts contributes to its power and legitimacy. However, more commonly, these judgments are not made pursuant to any objective study of what would be socially acceptable in a particular context. Rather, they reflect the moral attitudes of court justices (Smart, 1989). Reference is frequently made in the capacity to consent case law to forced medication as being “in the patient’s best interest.” However, the patient’s “best interests” are not supposed to be considered in capacity to consent hearings as an “objective” test for capacity is supposed to be the

determining factor. The language of “best interests,” does, however, continue to surface in these proceedings.

Freedom and the Intersection of Law and Psychiatry

Our current political landscape is highly concerned with questions of freedom: “over what it is, what it should be, what purports to be freedom whilst being its opposite” (Rose, 1999b, 94). These debates figure prominently within the concerns of moral philosophy and questions regarding limitations of government interventions (ibid.). An example of this is debates over capacity to consent: when and where do “best interests” and public security trump freedom to choose, or refuse, psychiatric treatment?

Presumptions of capacity for self-governance also inform moral and ethical discussions and policy debates. Debates arise surrounding the point at which freedom of agency must give way to (imposed) human well-being and which public policies are an appropriate response to these questions (Tobias, 2005, 82). Dean gives as an example policies enacted to ensure people receiving social benefits are required to attend meetings and counselling sessions (Dean, 1999). Likewise, subjects of community treatment orders are obliged, as part of the prescribed treatment plan, to attend appointments with psychiatric professionals, receive treatment under monitored conditions, attend counselling sessions, group meetings and live in specified residences under pain of enforced commitment. Failure to meet these conditions means failing to meet the obligations of a self-disciplined citizen.

Tobias' approach suggests that a certain degree of human functioning is a prerequisite to both personal freedom and self-creation and that these boundaries are culturally and historically determined (Tobias, 2005). It is of no use to grant the patient autonomy where they are lacking the capacity for freedom. Freedom, according to Foucault, can also mean being free from impulses and delusions: "being free means not being a slave to oneself and one's appetites" (Foucault, 1997, 286).

This concept of freedom brings to mind the work of Émile Durkheim. Durkheim concluded that what is moral is that which makes man [sic] "regulate his actions by something other than the promptings of his own egoism" (1984, 331). Those who are unable to self-regulate their actions or are unconscious of their actions will lose freedom since freedom is only truly achieved where one is able to control their desires through discipline (1985, 177). An autonomous individual is one who has managed to internalize a society's rules of moral conduct; not by blindly conforming to those rules but by having the intellectual capacity to rationally do so (Durkheim, 1985, 179).

In this chapter I have discussed the traditional theoretical approaches to capacity to consent and how a genealogical approach responds to the short-comings of dichotomous questions of legitimate and illegitimate power. A genealogical approach to a topic, in this case, capacity to consent, considers the "conditions of possibility" which give rise to a particular phenomenon, or, as Hunt and Wickham define it, "what combination of circumstances in dispersed and seemingly unconnected fields of social activity combines in such a way to give rise to some outcome" (1994, 6). Adopting this approach to the

present study of capacity to consent to psychiatric treatment allows us to view the use of capacity to consent law as a form of legal governance of psychiatric subjects. In doing so, we can explore how mental capacity, as a legal and psychiatric concept, has developed alongside a particular route of social economy: the emergence of neo-liberalism.

I have discussed the “conditions of possibility” aligned with the emergence of neo-liberal doctrine according to governmentality theorists: political divestment, deinstitutionalization, assumptions of self-regulating entrepreneurial subjects based on theories of the “psy sciences,” and the proliferation of “risk” discourses. These strategies of governance all have produced regulatory effects and those effects are felt throughout society – this thesis examines one microcosm of those effects – the governance of psychiatric subjects.

Chapter Three: Method Principles for the Sociology of Capacity to Consent Law as Governance

In order to study how the concept of the incapacity to consent to psychiatric treatment is treated in Ontario, I conduct a discourse analysis of the texts (the written legal decisions, or case law) on capacity to consent. Specifically, I follow the “method principles for the sociology of law as governance” developed by Hunt and Wickham (1994). This genealogical account of ways in which law serves to govern the conduct of subjects is a form of Foucauldian discourse analysis. This chapter on method principles will serve to define discourse analysis, the genealogical approach, the principles of the sociology of law as governance and why this approach is appropriate for the present study. I will then explain how I gathered the sample of case law to be analyzed and the questions I will pose in relation to those texts.

The analysis of discourse:

Discourse may be defined as :

[A] group of statements which provide a language for talking about – a way of representing knowledge about – a particular topic at a particular historical moment [...]. Discourse is about the production of knowledge through language. But [...] since all social practices entail *meaning*, and meanings shape and influence what we do – our conduct – all practices have a discursive aspect (Hall, 1992, 291, in Hall, 1997, 44).

Discourse is therefore not only spoken or written language, it also encompasses actions, ways of doing things, or practices. Discourse combines what is said (language) with what is done (practice) within a historical context. This could mean, for example, the

practices of restraining a psychiatric patient, confining them to a solitary space, or means of governing their behaviour in the community.

Discourses are productive - they define and produce our objects of knowledge as well as our ways of doing things. They govern the way a topic can be meaningfully talked about and reasoned. They also influence how those meanings are put into practice and used to regulate the conduct of others (Hall, 1997, 44).

Just as a discourse defines the possible ways a topic may be spoken about and acted upon, so too does it delineate ways a topic may *not* be understood or talked about (Hall, 1997, 44). The ways a topic comes to be spoken about and acted upon becomes the dominant, or “common sense” discourse on that topic (McKee, 2003, 100). Other ways of defining, thinking about, or acting upon a concept, are, by contrast, subverted and marginalized.

A focus on the language used in legal decisions allows us to investigate law as a site of production of knowledge. An analysis of language allows us to view how power and knowledge come together to pronounce the “truth” about a subject. As Feldman has stated, language is at once a technique of and effect of power. Language produces and re-produces both meaning and social reality (Feldman, 1998, 258). Therefore, focusing on the language used by the courts in written decisions is one way of finding evidence for how an issue is understood and what that means for subjects involved. Language is also “an instrument for producing new forms of thought about persons, and new ways of

calculating those very areas of human affairs which need to be managed and governed” (McCallum, 1997, 57). Language is therefore an “intellectual technology” ... a technology aimed at the production of knowledge that categorizes subjects in order that certain populations may be managed and governed (Miller and Rose 1988, 1990 in McCallun, 1997, 57). Given this, analyzing the discourse of capacity to consent to psychiatric treatment is a method by which to view how psychiatric patients come to become understood as “incapable” and how the conduct of the incapable subject is then governed. It has been well documented that language surrounding determinations of “incompetency” and/or “incapacity” “conveys many linguistic nuances” (Silberfield, 1990, 37) and that, furthermore, the use of this language conveys statements concerning the subject’s “social worth” (Alexander and Lewin, 1972, 18-20 in Carney, 1997, 1).

This focus on discourse as a sociological method is part of the “linguistic turn” in social theory. The linguistic turn, as it applies to mental illness, is part of a project that “attempts to place ‘mental illness’ within the realms of history, culture, and politics...” (Fee, 2000, 2). From this perspective, mental illness, and concepts associated with it, such as mental incapacity, are not argued to be “problems,” but “problems of knowledge” (Fee, 2000, 2). According to Purvis and Hunt, “[d]iscourse theory is one of the major consequences of the *linguistic* turn, that marks a break from action theory and focuses on the centrality of the ‘linguistic constitution’ of the social” (1993, 480). The subject is no longer viewed as constituted through ideology but as produced through discourse. The subject is no longer seen as an independent creator of meaning. The contention of modern theory and of the Enlightenment project that individuals are autonomous, free-

willed, rational beings is replaced by the idea that subjects are produced through discourse, power, and knowledge.

The genealogical approach:

The central theoretical concepts behind a genealogical account are discourse, power, and knowledge (Carabine, 2001, 267). This “means that we read discourses as, on the one hand, being infused with power/knowledge and, on the other, as playing a role in producing power/knowledge networks” (Carabine, 2001, 268). So, when we “read” discourses we examine them with an understanding that the object under investigation is replete with relations of power/knowledge. Dominant discourses will define what is understood as the “truth” at a particular historical moment, but “counter-discourses” are also present – those subverted discourses that resist and pose a challenge to the dominant discourse (ibid.). Therefore, the account I offer of capacity to consent to psychiatric treatment examines the dominant discourse as well as the challenges made to that discourse.

A genealogical approach rejects the traditional social science preoccupation with cause and effect because these methods of research are based on particular assumptions about human subjects; specifically about human intentionality and rationality (Hunt and Wickham, 1994, 6). Instead, Foucault’s genealogical approach denies both of these assumptions by tracing the “conditions of possibility” of a particular topic: “what combination of circumstances in dispersed and seemingly unconnected fields of social activity combines in such a way as to give rise to some outcome?” (Ibid.).

An analytics of governance:

As an analysis of law as governance, this thesis is part of a wider analytics of government within our current mode of political rationality, neo-liberalism. An analytics of government is concerned primarily with how knowledge is used within programmes aimed at directing and reforming conduct. “An analytics of government thus views practices in their complex and variable relations to the different ways in which ‘truth’ is produced in social, cultural and political practices” (Dean, 1999: 18). Those “truths” become the means by which we govern others but also *ourselves*. By examining programmes, such as the community treatment order, as a means of governing a certain category of subject, psychiatric subjects found incapable of consenting to treatment, I aim to show how this practice is also symbolic of how we govern *ourselves* – how we govern ourselves in adherence to the *duty to be well*.

Dean refers to the types of knowledge that are formed by, but also *inform* governance as the “*episteme of government*” (1999, 31). An analytics of government examines “the emergence of particular ‘regimes of truth’ concerning the conduct of conduct, ways of speaking truth, persons authorized to speak truths, ways of enacting truths and the costs of so doing” (Rose, 1999b, 19). These studies are concerned with the “conditions of possibility” for those “regimes of truth” (ibid.). Likewise, this study of capacity to consent examines what “conditions of possibility” – social, political, economic, and forms of expertise (i.e., from the “psy sciences”) – made possible the contemporary way capacity is determined and what strategies are aimed at the incapable psychiatric subject.

Along with giving rise to specific forms of knowledge and truth, practices of governing give rise to specific identities, both of the governed and the governors. Dean points to specific questions of identity that make up an analytics of government:

[W]hat forms of person, self and identity are presupposed by different practices of government and what sorts of transformation do these practices seek? What statuses, capacities, attributes and orientations are assumed of those who exercise authority (from politicians and bureaucrats to professionals and therapists)? What forms of conduct are expected of them? What duties and rights do they have? How are these capacities and attributes to be fostered? How are these duties enforced and rights ensured? How are certain aspects of conduct problematized? How are they then reformed? How are certain individuals and populations made to identify with certain groups, to become virtuous and active citizens, and so on? (Dean, 1999, 32).

These are the forms of questions to be asked concerning the identity of a psychiatric subject as “incapable of consenting.” Specifically, I argue that the neo-liberal practices of governing the incapable psychiatric subject seek to transform that subject into an entrepreneurial subject – one responsible for their own health status, for reducing the “risk of harm” to themselves and to others – one *obliged to be free* – even if that freedom remains ultimately constrained.

Commonsense

An analytics of government challenges “commonsense” notions and “taken-for-granted” ways of understanding topics (Dean, 1999, 21), such as, in this case, mental capacity. Foucault, for example, challenges the common-sense reality of topics such as insanity or illness. In doing so, he is not denying their existence but questioning the taken-for-granted approach to these subjects (Hunt and Wickham, 1994, 4). An analytics of government examines the means by which these commonsense notions arise and take on

the status of truth. This involves analyzing various “regimes of practice” which intermesh and which involve a variety of systems (ibid.), in this case the mental health and justice systems. “Regimes of practice” are “historically constituted assemblages through which we do such things as cure, care, relieve, punish, educate, train and counsel” (Dean, 1999, 30). These practices of government also assume particular types of subjects, with particular “capacities” and liberties. In order to examine the work of governing, then, one examines how subjects are formed and what capacity for agency is assumed (Dean, 1999, 29). Indeed, the legal governance of psychiatric subjects assumes certain (lack of) capabilities and actions, which will be fully examined in the following chapters.

Hunt and Wickham’s Method Principles for the Sociology of Law as Governance:

Hunt and Wickham have incorporated the features of a genealogical account of governance and formulated a way to examine specifically how law governs conduct. They propose four principles for this method of inquiry, which I will use as a guide to the “sociology of consent and capacity law as governance.”

Principle 1: The sociology of law as governance works to compile social facts in a genealogical manner (1994, 117). In other words, one looks at the “conditions of possibility” behind these social facts by asking “how are these social facts possible” (1994, 118).

Principle 2: The tools employed by the sociology of law as governance are attention to detail and careful generalization (1994, 120). This method examines the “attempt-failure-attempt” cycle of legal management, since

legal attempts at control are never total and always contain elements of incompleteness. Attempts to achieve control are met with resistance. Complete control, according to Foucault, is the result of relations of violence, not relations of power. Techniques and strategies of legal governance are investigated, as well as any challenges made to these techniques (1994, 120). While generalizations are carefully made, they are no guarantee and do not claim to represent the “truth.” Therefore, this type of inquiry is never used to make predictions (1994, 121).

Principle 3: The work produced as part of a sociological inquiry of law as governance remains distinguished from the way those results are used (1994, 122). The details and generalizations made might be used by any number of actors for any number of purposes. It “does not produce ‘explanations’” for the social facts it examines (1994, 124). The sociology of law as governance addresses “how” questions, not “why” questions. In keeping with this principle, the aim of this study on capacity to consent law is to add the body of knowledge produced within the growing body of work on analytics of governance.

Principle 4: The sociology of law as governance “must be continuously aware of its own institutional nature” (125) – that it too produces and (re) produces knowledge about subjects.

An analysis of Ontario's legal governance of incapable psychiatric patients:

The jurisdiction of Ontario was chosen because the most important case on this issue, the 2003 Supreme Court decision in *Starson v. Swayze*, emerged from the Ontario courts. Additionally, a preliminary search for case law covering all of the common law provinces (e.g., excluding Quebec) was conducted using the National Reporter System database. Of the cases listed under the topic "Persons of Unsound Mind" (which includes cases involving commitment orders and findings with respect to capacity to consent to treatment), 58 of the 61 cases found were brought before Ontario courts. It should be noted that not all of these cases involve treatment decisions; some involve the capacity to administer property or the determination of involuntary status.

The object of analysis is case law from Ontario's Consent and Capacity Review Board, Superior Court, Court of Appeal and the Supreme Court of Canada. The goal was to gather cases where the patient was appealing a physician's finding that they were incapable of consenting to psychiatric treatment. This includes patients who were involuntarily admitted to a facility as well as patients who were placed on community treatment orders.

Cases from the Ontario Superior Court, Ontario Court of Appeal and Supreme Court of Canada were found using a combined search method designed to yield all of the cases available to the public. The first database used was the Canadian Legal Information Institute website database (<http://www.canlii.com>). Using the query, "capacity to consent" + "consent and capacity board" yielded thirty-two (32) cases in December, 2005. The term "consent and capacity

board” was used since all cases from patients appealing their incapable status originate in this tribunal and any cases on appeal from the Board make reference to that decision. It was therefore a means of eliminating hundreds of cases that were irrelevant to the present study. Nine of the thirty-two cases were discarded due to irrelevance since they dealt with questions of capacity to consent to admission into a long-term care facility or a question of a substitute decision-makers consent to treatment to prolong life, capacity to manage property or a question of costs of the proceedings. In total, twenty-three (23) cases were gathered from this query.

In May, 2006 another search was performed using the Lexis-Nexis legal database search engine using the query [incapacity (or capacity) + consent + psychiatric + treatment]. This yielded a total of 92 cases in Ontario. Many of these were irrelevant since they dealt with questions of capacity to manage property, admission to a long-term care facility, or criminal or family law matters. After eliminating the irrelevant cases and duplicate cases found from the Canadian Legal Information Institute, five (5) cases were added to the sample. The remaining two cases were found by searching the Indexes to the Ontario Reports and Administrative Law Reports volumes under the categories “Mental Health” and “Persons of Unsound Mind.” In all, thirty (30) cases were analyzed from the Supreme Court of Canada, Ontario’s Court of Appeal and Superior Court levels.

Decisions from the Capacity and Consent Board (CCB) were retrieved from the Canadian Legal Information Institute website database (<http://www.canlii.com/on/cas/onccb/>). Decisions on this site have only been made available since June 1, 2003. However, certain selected decisions before this date have also been made available through this site. Access to these decisions is

therefore limited in scope and is not representative of the complete timeline of cases from this tribunal. The present analysis is likewise limited in that respect. Given these limitations, I included only cases from this database where patients applied for a review of a finding of incapacity to consent to a community treatment order. The “treatment” these subjects have been found incapable of consenting to in these cases is the “treatment order” itself. This affords an analysis of the emerging jurisprudence on CTOs as a means of governing certain incapable psychiatric subjects. In total, sixteen (16) cases from the CCB were analyzed. It should be noted, however, that two cases from the Superior Court also deal with the capacity to consent to a community treatment order.

A discourse analysis of legal decisions:

The following five elements of Foucauldian discourse analysis will be applied to the written decisions: 1. Statements about capacity to consent and mental disorder/illness that give us knowledge about these concepts; 2. The rules which govern the ways we can and cannot talk about capacity to consent and the mental disorders underlying that capacity; 3. Statements that describe subjects who resist their status as incapacitated; 4. How particular knowledge about this phenomena becomes dominant, thus acquiring authority and the status of “truth” about the concept and what knowledge about the concept becomes subverted; and 5. The institutional practices directed at regulating the conduct of these subjects – i.e., the psychiatric treatment proposed, and the institutional arrangements (adapted from Hall, 1997, 45).

Given the foregoing, a number of questions will be posed to the texts: What are the ways of describing the subjects and their capacity to consent to psychiatric treatment? What criteria lead the examining psychiatrists, capacity board members, or court justices to pronounce as to the patient's capacity to consent to treatment? What is the diagnosed psychiatric disorder? Is there evidence of opposing expert opinions on the diagnosis? Is the subject described as recognizing their condition as a mental illness? Is this made to be a determining factor in the finding of incapacity? What pronouncements are made in the decisions with respect to freedom, autonomy, rights, risks and harm (e.g. risk of harm to the self, to others, risks involved in following or not following the proposed treatment)? What pronouncements are made concerning the proposed or past treatments (e.g. their effectiveness, necessity or side effects)? Was the finding of incapacity overturned?

An analysis based on these questions will be presented in chapters four, five and six. This analysis will explore the dominant and counter discourses surrounding capacity to consent and the formation of the identity of the incapable psychiatric subject. The ways of defining, thinking about and acting upon incapacity will be discussed. I will show how the dominant discourse on incapacity to consent to psychiatric treatment is aligned with the dominant form of political rationality, neo-liberalism, and what that says about our "freedom to choose" on a broader level.

Chapter Four: The Truth Obligation: Insight Into Illness

This is the first of three chapters presenting an analysis of Ontario's capacity to consent case law. Through this analysis I aim to show how the concept of capacity to consent to psychiatric treatment is understood, what ways of talking about it dominate and take on the status of "truth" and what ways are discounted, as enunciated in these official psycho-legal documents. I will examine how these texts reconcile the competing goals of capacity to consent legislation: to uphold autonomy rights while reducing the risk of harm. I will also show what these texts say about psychiatric subjects and our understanding of the incapable psychiatric subject. Finally, I will examine the strategies aligned with capacity to consent law, namely, how the goals of capacity to consent decisions are aligned with the doctrine of neo-liberalism.

The official definition of capacity to consent is found at section 4(1) of the *Health Care Consent Act*:

A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

The discussion in Canada's leading case on capacity to consent, *Starson v. Swayze*⁴⁷, specifies how that definition is operationalized. The legal determination of capacity to consent to psychiatric treatment involves three considerations: 1) the patient's insight into their condition,

⁴⁷ *Starson v. Swayze* [2003] 304 N.R. 326 (SCC)

2) the evidence of treatment effectiveness, and 3) the goals and consequences of treatment or lack of treatment.

Regarding the first matter, the patient's insight, the Supreme Court argued "... if the patient's condition results in him being unable to recognize that he is affected by its manifestations, he will be unable to apply the relevant information to his circumstances, and unable to appreciate the consequences of his decision."⁴⁸ Starson, they found, was able to meet this criteria and was therefore deemed *capable* of making his own treatment decisions.

The second matter under consideration was whether or not the psychiatrists could show evidence of benefits resulting from the treatments previously forced on Professor Starson.⁴⁹ The Court of Appeal concluded that the psychiatrists showed no evidence in this regard. Dr. Swayze even admitted that none of the drugs Professor Starson had received permitted him to function even "adequately", and that it was "unclear" whether they ever would. Moreover, Starson explained that the side effects of the treatments had been "the most horrible experiences of my life."⁵⁰ For these reasons, the Court of Appeal described Starson's medication refusal as "logical" and noted that he "prefers to work on his problems in a therapeutic relationship with Dr. Posner, without taking psychiatric medications."⁵¹ For Starson, meeting the capacity criteria confers a right to choose a

⁴⁸ *Starson v. Swayze* [2003] 304 N.R. 326 (SCC), par. 79.

⁴⁹ *Starson v. Swayze* (2001) 146 O.A.C. 121, 201 D.L.R. (4th) 123, 33 Admin. L.R. (3d) 315, par. 11.

⁵⁰ *Starson v. Swayze* (2001) 146 O.A.C. 121, 201 D.L.R. (4th) 123, 33 Admin. L.R. (3d) 315, par. 11.

⁵¹ *Starson v. Swayze* (2001) 146 O.A.C. 121, 201 D.L.R. (4th) 123, 33 Admin. L.R. (3d) 315, par. 11.

counter mode of treatment, therapy, whereas, had he been found incapable he would have been forced to comply with the dominant mode of treatment, psychopharmaceuticals.

The potential consequences of treatment or a lack of treatment was the third matter considered. Starson's psychiatrists stated their treatment goal was the "normalization" of Starson's brain. However, the Court quickly pointed out the potential problem of normalizing measures:

The intended effect of the psychiatric medications was to slow down Professor Starson's thinking to more "normal" levels. The medication would slow his brain to the point where he cannot pursue the one thing that gives his life meaning: his scientific research.⁵²

For Starson, "normalizing" would render him unable to pursue his work. In this case, the consequences of treatment were considered worse than the consequences of a lack of treatment since the proposed treatments failed to show any benefits in the past *and* the perceived consequence of treatment was undesirable.

In this and the following chapters, I will examine how each of these considerations get taken into account by the Consent and Capacity Board and the Courts and what debates surrounding these questions say about freedom, autonomy, security, the risk of harm, and, ultimately the obligation to adhere to neo-liberal ideals.

This first chapter will examine the means by which subjects are determined to be capable or incapable of forming consent. The intersection of legal and psychiatric discourses will be discussed as will the point at which the legal and psychiatric arguments divide. Since

⁵² *Starson v. Swayze* (2001) 146 O.A.C. 121, 201 D.L.R. (4th) 123, 33 Admin. L.R. (3d) 315, par. 12.

the subject's status of "incapable of consenting to psychiatric treatment" was overturned in only eight of the forty-six cases (and three of these referred to the same patient, Scott Starson), it is evident that, in practice, an affinity exists between the legal and psychiatric discourses on capacity to consent. The dividing point, however, I argue, lies where the subject is either able or unable to articulate insight into their condition. This insight affords the subject the freedom to exercise their right to self-determination. Insight is thus a condition of freedom, including the freedom to take "risks" with their health. Failure to meet the conditions of freedom results in the *obligation* to be healthy in line with the "duty to be well." Insight, in these texts, is equated with capacities for self-knowledge and self-care, in other words, capacities of the neo-liberal entrepreneurial subject.

While the discourse on insight into illness is upheld in line with the dominant medical model on psychiatric illness, some limitations are placed by the Courts on the extent to which a patient must articulate knowledge of their condition in line with that held by psychiatric experts. In these cases, law exercises its authority over psychiatry. This is most notable where psychiatrists adopt a "best interests" argument. While such an argument is intrinsic to a therapeutic "right to treatment" doctrine, it extends beyond the boundaries of the appearance of scientificity required of an objectifying practice.

In chapter five I examine competing notions of risk of harm found in the legal decisions. What gets turned into an object of risk according to the texts and how are debates surrounding those risk objects resolved? These cases weigh the risks and benefits of

treatment against the risks and benefits of *non* treatment. The discourse concerning those risks changes over the historical timeline of the capacity to consent case law. As the arsenal of “newer and better” psychopharmaceuticals was developed, failure on the part of the psychiatric subject to “see the light” vis-à-vis their benefits gets taken as “proof” of unreasonableness and leads to a finding of incapacity. Dominant and counter discourses on these risks and the capacity of subjects to “reasonably” negotiate them emerge from these texts. It is evident that voices of the “sane” dominate over the marginalized voices of the “insane.”

In chapter six I show the alignment between the goals of enforced treatment of the mentally incapable and the rationalities of neo-liberalism. Finding a psychiatric subject incapable of consenting is a means of legitimating forced psychopharmaceutical treatment. Through this treatment attempts are made to “normalize” the subject, to bring about freedom from the manifestations of their conditions, and, ultimately, to produce an entrepreneurial subject: a responsible, risk-adverse, self-governing agent who is in charge of his/her wellbeing.

This strategy of legal governance of the incapable psychiatric subject, I argue, legitimizes the province’s divestment in mental health care facilities while simultaneously increasing its interventionist powers. This exemplifies the contradictory nature of neo-liberal governance. Furthermore, it serves as a microcosm of the exercise of freedom, autonomy and security at large: we are all subject to the doctrine of contemporary entrepreneurialism – the choices we are free to make are constrained to the extent that we

are obliged to direct ourselves as responsible, risk-adverse citizens. Foucault's concept of the panopticon as a metaphor for self-governance is instrumental here. Since one can never be certain whether or not they are being observed, each subject conducts him- or herself as though they are under constant surveillance (Rabinow, 1984, 19). Where one fails to self-govern, imprisonment follows.

The concepts of capacity, and its precursor, competency, have been described as “gate keeping” concepts (Faden and Beauchamp, 1986, Somerville, 1994). Somerville goes so far as to call competency the “‘gate-keeper’ of the ‘gate-keeping’ concepts” (1994, 183). Meeting the requirements for competency calls into play the consideration of other concepts, namely autonomy and self-determination (Somerville, 1994, 182). In law, Somerville notes, the terms “autonomy” and “self-determination” may be used interchangeably even though “autonomy refers to the *capacity* for self-determination [...] whereas self-determination refers to the *exercise of this capacity*” (1994, 185-186). What happens in legal practice, however, is that the determination of individual autonomy gets treated as a question of fact “usually by a court as a passing reference to a given person’s state of mind” (1994, 188). Questions of capacity, autonomy and self-determination therefore rely upon the intersection of law and psychiatry. I will expand upon the affinity between legal and psychiatric discourses and the emergence of a “psycho-legal” discourse further in this chapter.

As a gate-keeper concept, questions of capacity necessarily set up a division between “capable” and “incapable.” I therefore argue that capacity to consent judgments employ

dividing practices (Foucault, 1982); those practices which divide the sick from healthy, mad from sane, and, in this case, capable from incapable. “Essentially, ‘dividing practices’ are modes of manipulation that combine the mediation of a science (or pseudo-science) and the practice of exclusion – usually in a spatial sense, but always in a social one” (Rabinow, 1984, 8). In these cases, the incapable are separated in a spatial sense through involuntary institutionalization or, for those governed by community treatment orders, by their obligation to comply with the stipulations of that order while living in the community, which may include living in specified housing.

Insight and the Medical Model

The division of psychiatric subjects along the line of insight is legitimated by the dominant understanding of mental illness. This model argues that approximately half of all people diagnosed with a severe mental illness do not agree with the assessment of their condition and, consequently, either do not seek, or resist, treatment (Gray and O’Reilly, 2005, 20). The *American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders* (DSM) began associating lack of insight with mood disorders in 1987 (version DSM-III-R). For example, under the associative features of Bipolar disorder it is noted that “[f]requently the person does not recognize that he or she is ill and resists all efforts to be treated” (1987, 216). Critics of capacity to consent laws, however, argue that the lack of insight is too frequently conflated with mental incapacity such that failure to recognize or agree with a diagnosis of mental illness is typically viewed as evidence of incapacity to consent.

According to the capacity to consent decisions, the psychiatric subject's recognition of the presence of a mental illness, even if they don't agree with the label, is paramount for capacity to consent to treatment to be recognized. The patient, however, has an upward battle to win in order to convince the courts of that recognition. As Holstein has argued, judges in psychiatric hearings operate against the background of an assumption of madness, therefore, the patient's reliability is consistently challenged. "Cast in this light, their testimony and behaviour is always suspect, their credibility is constantly challenged and their claimed capabilities discounted. Behaviour that might pass for 'normal' or 'competent' is regarded as artificial or transitory" (Holstein, 1987, 155).

Part of that challenge is due to the fact that dominant understanding of mental illness is that of a state in which the individual's ability to reason with respect to their mental condition is eroded. This association is also held to be true by the courts. In the concluding arguments in *Duarte v. Kingston Psychiatric Hospital* (1999) the Court notes that,

[S]chizophrenia does not provide the sufferer with the ability to diagnose the fact that he or she suffers from the illness [...] it is not enough to say that because one understands about schizophrenia, that he or she must therefore not have the illness. The medical authorities have diagnosed the appellant with the illness, and the Board accepted that diagnosis and decided the appellant was not capable with respect to treatment of his mental disorder.⁵³

The medical model is thus mirrored and legitimated in the legal discourse. In this case, the patient failed to acknowledge the existence of mental illness in the required manner. There is also an assumption made in the above statement that medical authorities have access to true knowledge concerning the patient's condition, and that the patient, because

⁵³ *Duarte v. Kingston Psychiatric Hospital et al.* (2000) O.T.C. LEXIS 1100, 2000 OTC Uned 896, par. 11.

of his illness, is unable to see this truth. This establishes a situation of disciplinary power over the patient by the physician. As Lupton notes, “[f]rom the Foucauldian perspective, power as it operates in the medical encounter is a disciplinary power that provides guidelines about how patients should understand, regulate and experience their bodies” (1997, 99). In this case, the patient’s understanding, care of and experience of their minds must follow that of the dominant psychiatric model – “one must show one’s wounds in order to be cured” (Foucault, 1997, 244).

Failure of Self-Knowledge

The first consideration, whether or not the patient articulates insight into their illness, is viewed, I argue, as a failure of self-knowledge. Closely related to this obligation of self-knowledge is the obligation of the psychiatric subject to engage in adequate self-care. Both are taken as evidence of failure to adhere to the truth obligation imposed by the dominant medical model and of an inability to ascribe to the contemporary technologies of the self. This conception of mental capacity falls in line with the political doctrine of neo-liberalism. “Neo-liberalism calls upon the individual to enter into the process of his or her own self-governance through processes of endless self-examination, self-care and self-improvement.” Those who fail to “care for the self” are hence viewed as a public health burden (Petersen 1997, 194). Where that process of self-government is not forthcoming due to the manifestations of a mental condition, the subject will still have those conditions of governance imposed upon her.

The extent to which manifestations of a condition erode capacity to consent is discussed in the decisions. In *D'Almeida v. Goyer*, it was noted that the Courts have established that although mental illness may prevent a person from appreciating their illness, “[I]t would not be sufficient to say the person lacked capacity solely because they denied any illness. The evidence would have to establish that the denial was caused by the illness and was not based on some *rational* ground.”⁵⁴ Where is the line drawn whereby illness is or is not the source of denial? What is considered *rational*?

Delusions⁵⁵ are frequently cited as the source of denial and, hence, the inability to understand and appreciate the consequences of treatment or a lack of treatment. For example, Ms. Howlett, a 79-year-old woman with a history of psychiatric diagnosis, was said to suffer from delusions to such a degree that she “lacked the understanding of the nature of her illness,” and was therefore found to be not mentally competent.⁵⁶

In *Khan v. St. Thomas*, despite finding that the Board had erroneously applied the test for capacity, the Court concluded that Ms. Khan was not competent to consent to the proposed treatment. The reason given by the Court for this conclusion was that Khan’s delusions limited her ability to understand the information concerning the intended effects of the medication.⁵⁷

Again, in *Roy v. Furst*, the Court specified,

⁵⁴ *D'Almeida v. Goyer* [1999] 104 O.T.C. 326, par. 7, my emphasis.

⁵⁵ “The hearing of voices has become one of the key limits or mechanisms through which *danger* and *risk* are adjudicated within both the legal and ‘psy’ apparatus” (Blackman, 2000: 59).

⁵⁶ *Howlett v. Karunaratne* (1988) 64 O.R. (2d) 418 (Dist. Ct), Head note.

⁵⁷ *Khan v. St. Thomas Psychiatric Hospital* (1992) 7 O.R. (3d) 303, p. 315, paragraphs d-e.

[I]t is not sufficient that a person have an intellectual understanding of the nature of his or her illness and the treatment proposed. [...] A person is not mentally capable if delusions render him or her incapable of understanding the information that is relevant to making a decision about the treatment and/or unable to appreciate the reasonably foreseeable consequences of a decision or lack of decision.⁵⁸

The apparent existence of delusions therefore trumps a subject's *irrational* understanding of his or her illness. Establishing that a person is delusional is thus a means by which subjects are divided in terms of their capacity to consent. It should, however, be noted that the two above cases involve women and that this may be indicative of a gendered reading of incapacity.

Limits to this division were further established in the Starson case. During the lengthy course of the Starson trials, it was decided that the existence of a mental disorder or of delusions alone does not render the person incapable of consenting. The Superior Court ruled:

[T]he mere presence of a mental disorder is not sufficient to support a finding of incapacity, nor is evidence of delusional thinking enough. It must be demonstrated that the disorder has rendered the person unable to understand the information relevant to decision making and unable to appreciate the consequences of a decision.⁵⁹

A distinction must be made, it was argued, between the *ability* to understand information and its consequences and the *failure* to do so. Furthermore, the psychiatrists were reminded that the test for capacity "is not to be based on what the attending physicians consider to be in the patient's 'best interests:'"

⁵⁸ *Roy v. Furst* 1999 O.T.C. LEXIS 732; 1999 OTC Uned. 333, par. 10.

⁵⁹ *Starson v. Swayze* (1999) 22 Admin L.R. (3d) 211, par. 13.

[C]apable individuals have the right to take risks and are presumed free to make decisions that are considered unreasonable. The test is not whether the choice by the patient appears reasonable or wise, but whether the patient is capable, within the meaning of the statute, of making the decision. The Board is not to inject its own personal values, judgments and priorities into the process.⁶⁰

A division is thus established between legal and psychiatric authorities, with law exercising its dominance, in this case, over the psychiatric discourse of right to treatment. Taking a stand against the “best interests” argument I see as an attempt to set the legal discourse away from the paternalistic tendency of psychiatry.

The Starson case also shows evidence that meeting the truth obligation, by recognizing the existence of one’s mental illness, allows the subject to put their health and their freedom at risk. The patient may well continue to be chained to their delusions as a result of their deteriorating condition, within the confines of a psychiatric institution, as was the case with Starson, yet retain their right to self-determination. This decision is in line with Drane’s model of incompetency: “To be competent to make apparently irrational and very dangerous choices, the patient must appreciate the implications of the medical information for his or her life” (Glass, 1997, 23).

While the legal and psychiatric discourses agree on the condition of insight, the legal discourse differs in degree to which the subject must adhere to the psychiatric “truth.” *Neto v. Klukach*⁶¹ was a case of a “37 year old separated mother of one child”. At the time of the hearing, she was diagnosed with bipolar disorder and was pregnant with her second child. Dr. Klukach based his finding of incapacity on Ms. Neto’s refusal to

⁶⁰ *Neto v. Klukach*, [2004] O.T.C. 138 (ON S.C.), par. 11.

⁶¹ *Neto v. Klukach*, [2004] O.T.C. 138 (ON S.C.)

acknowledge that she was bipolar and what he argued were her delusional beliefs about Lithium and cough syrup. The Court, however, concluded that to be found incapable, her delusional beliefs would have to pertain specifically to her proposed medications.⁶² Neto was therefore declared free and capable of making her own treatment choices.

A finding of incapacity to consent, on the other hand, effectively ends the patient's right to see their disorder in a manner inconsistent with the dominant psychiatric discourse, as was the case for Paul Conway:

Until 1996, Paul Conway was legally entitled to refuse to consent to treatment on the basis of his views regarding his own mental health, whether or not those views conformed to psychiatric assessments of his mental health. However, he is no longer entitled to do so, since he is no longer capable of giving or refusing consent to treatment.⁶³

Failure of Self-Care

Taking care of oneself requires knowing [*connaître*] oneself. Care of the self is, of course, knowledge [*connaissance*] of the self [...] but also knowledge of a number of rules of acceptable conduct or of principles that are both truths and prescriptions. To take care of the self is to equip oneself with these truths: this is where ethics is linked to the game of truth (Foucault, 1997, 285).

Failure of self-care is also taken as evidence of a lack of capacity to consent according to the case law. Furthermore, it is a risk associated with remaining untreated. For example, in *Kirpiev v. Peat*, the patient was described as being very well read and of above average intelligence. However, the patient was found to have “a very dramatic self neglect.”⁶⁴

This was evidenced by using unhygienic self-catheterization practices, living in filthy conditions in a rented motel room, having a carton of eggs in the oven with the oven on,

⁶² *Neto v. Klukach*, [2004] O.T.C. 138 (ON S.C.), par. 40.

⁶³ *Conway v. Jacques*, (June 17, 2002) ONCA C36001, par. 39.

⁶⁴ *Kirpiev v. Peat*, [2002] O.T.C. 488 (ON S.C.), par. 13.

and suffering from mal-nutrition. According to the Board, “the appellant was unable to appreciate the reasonable foreseeable consequences of his refusal to take anti-psychotic medication.”⁶⁵ The Board also found “that the appellant suffered from paranoia which posed future physical harm to himself and potential criminal activity towards others.”⁶⁶ This conclusion is said to stem from the patient’s failure of self-care as well as his denial of illness.⁶⁷ Self-neglect, risk of harm and dangerousness are hence all associated with the incapable psychiatric subject.

The “Catch-22:” “Accepting treatment means I’m ill”

Consistent in the legal decisions is the expression of various Catch-22 situations.

Denying illness is equated with incapacity, which leads to forced medication; acknowledging illness means one is in need of medication which once again leads to the risk of being medicated against one’s will. Some subjects were themselves capable of articulating this dilemma. For example, in *Duarte v. Kingston Psychiatric Hospital* (2000), Mr. Duarte stated, “Because I understand about schizophrenia, I know I don’t suffer from it, therefore I can refuse treatment because to accept treatment would be tantamount to admitting I had the illness.”⁶⁸

Similarly, when Professor Starson was before the Superior Court, and asked whether he agreed he had a psychiatric illness, he testified that this question left him in a “Catch 22” position:

⁶⁵ *Kirpiev v. Peat*, [2002] O.T.C. 488 (ON S.C.), par. 22.

⁶⁶ *Kirpiev v. Peat*, [2002] O.T.C. 488 (ON S.C.), par. 22.

⁶⁷ *Kirpiev v. Peat*, [2002] O.T.C. 488 (ON S.C.), pars. 13, 32.

⁶⁸ *Duarte v. Kingston Psychiatric Hospital et al.* (2000) O.T.C. LEXIS 1100, 2000 OTC Uned 896, par. 4.

He said that if he admitted having a mental illness then the psychiatrists would insist on treating him with medications he did not want to take. On the other hand, if he did not admit it, then the psychiatrists would say he "lacked insight" into his illness and use that as an indication of incompetence and then force treatment upon him.⁶⁹

Starson did however concede to having mental problems and that these problems had over the years made his life difficult. He also agreed that he "exhibited the symptoms of these labels that you give."⁷⁰ The Board, for its part, dismissed Starson's acknowledgements as insignificant and argued that Professor Starson was in "almost total denial" of his "mental disorder."⁷¹ This failure to acknowledge the existence of illness, to the Board, meant that Starson could not possibly understand the information concerning the proposed treatment provided to him since, they argued, he could not relate that information to his particular disorder.⁷²

Dominant discourses will define what is understood as the "truth" at a particular historical moment, but "counter-discourses" are also present – those subverted discourses that resist and pose a challenge to the dominant discourse (Carabine, 2001, 268). The dominant discourse of capacity to consent holds that insight into illness is a precondition of capacity. This discourse emerged in psychiatry and is appropriated by law to the extent that is argued as a legitimate limitation to the right of self-determination. Capacity confers the right to take "risks" with one's health, although, it should be pointed out, that legal arguments about the right and freedom of the capable subject to take risks and make

⁶⁹ *Starson v. Swayze* (1999) 22 Admin L.R. (3d) 211, par. 30.

⁷⁰ *Starson v. Swayze* (1999) 22 Admin L.R. (3d) 211, par. 31.

⁷¹ *Starson v. Swayze* (1999) 22 Admin L.R. (3d) 211, par. 23.

⁷² *Starson v. Swayze* (1999) 22 Admin L.R. (3d) 211, par. 34.

unreasonable choices only occurred in cases where the subject was an involuntary patient, not living in the community on a treatment order.

While in the majority of cases psychiatric discourses dominate, there are cases where legal authorities place limitations on that dominance. Psychiatric subjects still need to hold to certain “truths” concerning their condition, however, they do not need to appropriate the labels used by psychiatry nor are the manifestations of their condition always equated with a lack of capacity. The law specifies that these manifestations, such as delusions, only result in incapacity where they erode the patient’s ability to understand the information relevant to their treatment and appreciate its consequences.

Most importantly, however, is the exercise of legal authority over “best interests” arguments made by psychiatric experts. I argue that the paternalistic doctrine of “best interests” extends beyond the boundaries of the practice of objectification. It does not give the appearance of a scientific mode of objectifying the subject. Furthermore, the rejection of these arguments by Court justices breaks with the tendency of Law to make determinations of what is in an individual’s “best interests.”

A feature of neo-liberalism is “the active creation of new institutions and regulations of state and society” (Keil, 2002, 581). Smith (1989) argues that where medicine (including psychiatry) and law intersect they are experienced as a new specialized expertise, medico-legal expertise. Where law is invested with the authority to make judgments of facts of law and not judgments of psychiatric fact, the emergence of specialized tribunals

and therapeutic courts, such as drug courts and mental health courts, combine these authorities (Slovenko, 2004; Smith, 1989). Comprised as it is of a panel of both members of the bar and psychiatric professionals, Ontario's Consent and Capacity Board is one such newly emerged institution, in this case of psycho-legal expertise. Decisions from the Board, as seen here and in the following chapters, are more closely aligned with the dominant psychiatric discourses. Given that the "psy sciences" have been so instrumental in constructing both the entrepreneurial subject and neo-liberal forms of governance, the "psycho-legal" discourses emerging from this regulatory body have a particular affinity with neo-liberal rationalities.

Chapter Five: The “Risk(s) of Harm”

It is acknowledged that neuroleptic drugs are not all sweetness and light. For some they contain immense risks of nervous disorders and debilitating side effects. The case law of the United States overflows with the running debate between proponents of neuroleptics and those who say the risks of devastating side effects are totally unacceptable.⁷³

The second consideration, the efficacy of the proposed treatment, weighs the risk of harm to self from side effects against the risk of harm to self from non-treatment. Determining the efficacy of the proposed treatment involves the scientific objectification of the patient through the implementation of strategies of disciplinary power.

The central strategies of disciplinary power are observation, examination, measurement and the comparison of individuals against an established norm, bringing them into a field of visibility. It is exercised not primarily through direct coercion or violence (although it must be emphasized that these strategies are still used from time to time), but rather through persuading its subjects that certain ways of behaving and thinking are appropriate for them (Lupton, 1997, 99).

This statement is relevant because it highlights the situation of incapable psychiatric subjects. Strategies of “direct coercion or violence” are still used. However, new techniques of legal governance aim to persuade incapable psychiatric subjects to make “responsible” choices, however restrained they may be.

Nettleton points out that within the contemporary form of governance, experts present various risks which individuals are called upon to actively negotiate (1997, 208). This relationship governs the field of possible actions a subject may take (Foucault, 1982, 220-221). Health and health policy discourses however presuppose agency: that subjects are

⁷³ *Fleming v. Reid* (1990) (182 c)

free to challenge the knowledge presented within such discourses (Nettleton, 1997, 217). In the cases before us, the range of possible ways subjects may act vis-à-vis their diagnosis and treatment is constrained by both their status as incapable of consenting to treatment as well as by the symptoms of their conditions. They are nevertheless “persuaded that certain ways of behaving and thinking are appropriate for them.” In these cases, the proper way of behaving and thinking is to comply with a proposed regime of treatment and to acknowledge the benefits it may afford them. Indeed, failure on the part of the patient to “see the light” and agree with the benefits of proposed treatments and risks of remaining untreated results in the exercise of psycho-legal power to compel their treatment compliance.

An early example of the exercise of psycho-legal control can be found in the case of *T and the Board of Review* (1983). In this case the court was to decide whether ECT treatments fell into the definition of “psychosurgery” and whether or not the Board could authorize the physician to perform this treatment despite Ms. T’s *competent refusal*. Justice Van Camp arrived at his decision after a lengthy discussion about the wide-ranging and inconclusive evidence concerning the effectiveness of ECT. Leaving aside a number of studies showing the existence of brain tissue damage, Justice Van Camp chose the opinion of Dr. Berry that, “apart from the isolated occurrence of extremely rare complications, properly administered electroconvulsive therapy does not have any permanent effect on nerve cell bodies, conducting tracts or the continuity of normal brain tissue.”⁷⁴ ECT treatments were thereby ordered for the patient, despite the fact that she

⁷⁴ *Re T and Board of Review for the Western Region* (1983) 44 O.R. (2d) 153, par. 162 g.

had been found competent to consent, thus overriding the patient's competent medical wishes.

While the psychiatric mainstream touts the effectiveness of psychopharmaceuticals, the benefits of these drugs have been challenged by others. For example, the Court of Appeal in *Fleming v. Reid and Gallagher* (1991), stressed that “[neuroleptics] are not a cure.” In this case, a detailed list of potential side effects was provided, including dystonia (muscle spasms, particularly in the face and arms, irregular flexing, writhing or grimacing and protrusion of the tongue); akathisia (internal restlessness or agitation, an inability to sit still); akinesia (physical immobility and lack of spontaneity); and Parkinsonisms (mask-like facial expression, drooling, muscle stiffness, tremors, shuffling gait). The drugs can also cause a number of non-muscular side effects, such as blurred vision, dry mouth and throat, weight gain, dizziness, fainting, depression, low blood pressure, cardiovascular changes and, on occasion, sudden death.

The most potentially serious side effect of anti-psychotic drugs is a condition known as tardive dyskinesia. This is a generally irreversible neurological disorder characterized by involuntary, rhythmic and grotesque movement of the face, mouth, tongue, and jaw. The patient's extremities, neck, back and torso can also become involved. Tardive dyskinesia generally develops after prolonged use of the drugs, but it may appear after short term treatment and sometimes appears even after treatment has been discontinued. In short, it appears that although these drugs apparently operate so as to benefit many patients by alleviating their psychotic symptoms, they also carry with them significant, and often unpredictable, short term and long term risks of harmful side effects.⁷⁵

Reactions to medications are not only physically harmful but have important consequences for how the psychiatric subject is viewed. Breggin (1994, *infra*) suggests

⁷⁵ *Fleming v. Reid and Gallagher* (1991) 4 O.R. (3d) 74, p. 83-84.

that the bodily changes resulting from the chemical reactions to these medications actually mimic and are mistaken for symptoms of illness (in Fabris, 2006, 58-59).

This calls to mind Rose's observation that advanced liberal democracies are increasingly becoming "psychopharmacological societies" comprised of "neurochemical selves" (2003, 47). He argues that labels are attributed to psychiatric illnesses as phenomena that respond to and are potentially treatable by the pharmaceutical developed for it, such that psychiatric illnesses increasingly become defined by the particular reactions they have to given drugs (Rose, 2003, 52).

"Newer and better" medications:

It has been argued that since the dominant position on mental illness is the "brain-disease model," chemical solutions become the sole response to improving the lives of subjects. There is an absence of incentive for promoting anything other than "better living through chemistry" (Bassman, 2005, 490). Ontario's capacity to consent case law tends to bear this out.

When second-generation anti-psychotic medications arrived, they were presented as being more effective and having fewer risks of side-effects than first-generation anti-psychotics. However, among the risks of the newer anti-psychotics commonly cited in the case law are weight gain, increased cholesterol levels, diabetes and heart conditions. What gets argued by psychiatric authorities is that if the patient is unable to appreciate that these new medications offer greater benefits than the old ones, then he or she must be

incapable of giving consent. This argument was clearly presented by Dr. Jacques in *Conway v. Jacques*:

He is now categorically refusing and consequently been denied the opportunity to try the newer atypical antipsychotic medications which not only have fewer side effects but also are considerably more effective in dealing with certain symptoms in patients. The institution of these medications has in fact gone as far as to have resulted in certain persons improving to the extent that they have been released from this maximum secure facility when before the availability of these medications, these individuals would not ever be considered for release.⁷⁶

Potential release and freedom are hence seen as goals of the newer psychopharmaceuticals. The benefits of these chemical treatments are upheld in such a manner as to deny any challenge based upon the negative effects experienced from their use. This is important since subjects' experiences with these medications are often subverted while making assumptions about the benevolence of psychiatric experts and the treatments they prescribe (Fabris, 2006, 14).

Treatment Refusal Equals Incapacity:

There has been a historic tendency within both law and psychiatry to equate the refusal of treatment with the lack of capacity to consent to treatment. Gendreau observes that

[T]raditional psychiatric presumption that the acceptance of a treatment is, by definition, reasonable and healthy and that a refusal of a treatment is not only presumed unreasonable but also a symptom of mental illness. So understood, overriding a patient's decision is presumed justified when this decision is a refusal, whether the patient is competent or not (1997, 276).

An example of this presumption can be found in *Khan v. St. Thomas Psychiatric Hospital*. The appellant's counsel "argued that the board, like the attending physician, wrongly equated competence with acceptance of treatment and incompetence with

⁷⁶ *Conway v. Jacques*, (2002) ONCA C36001, par. 19

refusal.”⁷⁷ Her counsel explained that Dr. Komer found Ms. Thompson incapable of consenting to treatment only subsequent to her refusal to continue taking medication she had previously been taking voluntarily.⁷⁸ The Superior Court nonetheless sided with Dr. Komer and the Board’s decision, stating, “Ms. Khan can understand the medication and its side effects, but cannot apply them to herself. [Dr. Komer] said she does not understand the benefits of taking it because she does not believe she is ill.”⁷⁹ The legal and psychiatric discourses converge here where the patient fails to meet the insight obligation.

However, in *Boimier v. Swaminath* (2003), the Superior Court granted Mr. Boimier’s appeal from the Board’s decision to uphold a finding of incapacity to consent. The reason given for overturning the Board’s decision was that this was a classic case of equating treatment refusal with incapacity. After the Board refused to grant him a release, Boimier refused to take the medications he had been voluntarily consuming up to that point. When Dr. Swaminath saw that Mr. Boimier had stopped taking his medication, a decision with which he did not agree, he declared the patient to be incapable.⁸⁰

In addition to equating treatment refusal with incapacity, failure to acknowledge the benefits of treatment on the part of patients is also considered evidence of incapacity to consent. In Boimier’s case, it was concluded that Dr. Swaminath’s declaration of

⁷⁷ *Khan v. St. Thomas Psychiatric Hospital* (1992) 7 O.R. (3d) 303, par. 312 e.

⁷⁸ *Khan v. St. Thomas Psychiatric Hospital* (1992) 7 O.R. (3d) 303, par. 312 g.

⁷⁹ *Khan v. St. Thomas Psychiatric Hospital* (1992) 7 O.R. (3d) 303, par. 315 b.

⁸⁰ *Boimier v. Swaminath*, [2003] O.T.C. 644 (ON S.C.).

incapacity rested on his argument “that the patient does not understand that he might benefit from treatment and that treatment has helped him in the past.”⁸¹ The Judge in this case, however, argued that, “I have no doubt that Dr. Swaminath had his patient's best interests in mind when he prescribed this medication and when he declared Mr. Boimier incapable. The patient's best interests, however, are not the issue in this appeal.”⁸² Boimier was hence deemed capable of making his own treatment decisions. Again here, “best interest” arguments lie outside of the affinity between legal and psychiatric discourses.

Hiltz and Szigeti have found similar evidence of the tendency to equate treatment refusal and incapacity in their research:

The Board rarely receives an application for a review of a finding of treatment incapacity from an individual who wishes to receive the recommended treatment [...]. In practice, many physicians do not question the capacity of a patient who agrees with their treatment recommendation (Hiltz and Szigeti, 2004, 158).⁸³

In contrast to this, recognizing the benefits of medication brings the psychiatric subject the freedom to take risks. For example, R.R. acknowledged being helped by medication. His community treatment order was therefore revoked since he was found to be *capable* of consenting to it. If he had denied the benefits of medication, he may well have remained under that order.

RR’s ability to recognize that he suffered from mental illness and that medication had helped him was important and relevant to making a treatment decision. We were also satisfied that RR was able at the Hearing to appreciate the reasonably

⁸¹ *Boimier v. Swaminath*, [2003] O.T.C. 644 (ON S.C.), par. 19.

⁸² *Boimier v. Swaminath*, [2003] O.T.C. 644 (ON S.C.), par. 21.

⁸³ Koury and Philips-Nootens (2002) found the same correlation between treatment refusal and findings of incapacity.

foreseeable consequences of making or not making a treatment decision. As a result, RR has the right to take risks and to be wrong in his decisions.⁸⁴

Risks of Treatment Non-compliance

In addition to failing to appreciate the benefits of treatment, failure to fully appreciate the risks of *non-treatment* is another situation that potentially leads to a finding of incapacity. In *Chen v. Hillen* (2005) for example, the Court concluded, “On the facts of this case, the Board was entitled to conclude that the appellant’s acknowledgment that he would continue to be hospitalized did not constitute appreciation of the reasonably foreseeable consequences of a denial of treatment.”⁸⁵ The patient, presumably, needed to describe the specific deterioration of his mental condition that would ensue subsequent to remaining untreated.

Where the “treatment” in question is the “treatment plan” contained in a community treatment order, the principle risk associated with not being on the CTO is said to be the “decompensation,” or mental deterioration, which follows from the subject’s treatment non-compliance. The conditions for issuing a CTO are met where the subject has a history of hospitalization followed by treatment and stabilization, subsequent discharge, treatment non-compliance and deterioration, followed by re-admission to a hospital. The risks of being off of a CTO are generally described as a lower quality of life due to the deterioration of the patient’s condition. Absent a treatment order, it is argued, patients would fail to attend follow-up appointments and follow their medication routine. L.M., for example, is said to be at risk of “being disorganized” and becoming “spaced out.” In

⁸⁴ *R.R., Re*, 2004 CanLII 36179 (ON C.C.B.), www.canlii.org, accessed May 3, 2006

⁸⁵ *Chen v. Hillen* (2005) ONCA 9323, par. 5.

the past, this has led her to neglect her hygiene, leave the stove on thus creating a risk for fire, and causing a toilet to overflow. “If not treated, her mental disorder, which [her psychiatrist] diagnosed as schizophrenia, likely would result in substantial mental and physical deterioration of herself and substantial physical impairment of herself.”⁸⁶

Other risks cited in the judgments include alienation and homelessness. The latter risk, homelessness, is supported by Slovenko’s observation that the doctrine of the “least restrictive alternative,” of which CTOs are a part, supported the continued move to deinstitutionalization. However, the end result, unfortunately, “is well known: The mentally ill sleep on the streets” (2004, 583). The technology of legal governance issued in response to this problem is the notorious *Safe Streets Act*⁸⁷, legislation aimed at criminalizing homelessness and panhandling (Keil, 2002). A full analysis of the connections between that legislation and CTO provisions is, however, outside of the scope of this paper.

The “Slippery Slope” Argument: The “Risk of Future Harm”

According to Rose, the move to constructing individuals as “at risk” creates an extended role for “psy experts” – the prediction of future pathology. (Rose, 1998, 94-95).

This extended role is played out in the “psycho-legal” discourse in the prediction of “risk of future harm.” The members of the Consent and Capacity Board have argued that the CTO criteria do not need to be met at the time of a CTO hearing. It is sufficient to determine that a patient will have a future risk of harm in absence of a CTO. This

⁸⁶ *L.M., Re*, 2004 CanLII 51967 (ON C.C.B.), www.canlii.com, accessed May 5, 2006

⁸⁷ *Safe Streets Act*, 1999, S.O. 1999, c. 8.

argument, however, was not upheld by the Superior Court. In *Haugan v. Whelan* (2003), the Court referred to this as a “slippery slope” argument. According to the Board, there was no need to wait until Haugan met the criteria for a treatment order because once he goes off his medication he will be on the road to meeting the criteria of “substantial mental or physical impairment” set out in s. 15 (1.1) of the Act. The Court however, argued that, according to the psychiatrist’s own statements, it would be some two months after stopping medication that Haugan would meet that criteria. Furthermore, the judge noted it was not at the Board’s discretion to arbitrarily determine that one of the elements of the legislation was irrelevant. The treatment order was therefore quashed (par. 15).

There is also evidence that the “revolving door” syndrome need not be present in order for a CTO to be issued. The CTO is, as explained, used as a pre-emptive strike, a strategy of preventing the mere “risk” of relapse, harm, or dangerousness:

Counsel’s submission was that, since the applicant has had only two hospitalisations, the second occurring seven years after the first, it cannot be said that he has experienced the “revolving door” pattern (to use his expression) described in s.33.1(3). Clearly, it is a purpose of a community treatment order to prevent the pattern in question from occurring in the future, if there is evidence that such might become the case. Assuming that to be a constant requirement, one must ask whether a finding of such a future risk can be made only on the basis of the number of admissions that have already occurred and the interval between them. If so, what is a sufficient number? What is an acceptable interval? However, in our opinion, the confirmation of a CTO does not depend on the existence of such a past pattern, nor is it necessary that one is likely to emerge in the future.⁸⁸

This is a direct example of a risk strategy ostensibly designed to predict and prevent a possible eventuality. The assumption is that we need not wait until the patient shows signs that they meet the conditions of the CTO or that their lives would be improved by

⁸⁸ *Q.S., Re*, 2005 CanLII 7112 (ON C.C.B.), www.canlii.com, accessed May 5, 2006

being subject thereto; one need only show signs that they are “at risk” of meeting the requirements.

In *Kirpiev v. Peat* (2002), the Board argued that the patient was at risk of “future physical harm to himself and potential criminal activity towards others.”⁸⁹ The noted risks of the proposed treatment to the patient are weight gain, drowsiness, and a past reaction to Haldol, which resulted in dystonia. The Court made a statement concerning patient autonomy and the balancing of risks but never the less supported the Board’s finding of incapacity on the basis of future harm and potential dangerousness:

The right to be free from unwanted medical treatment is a constitutionally protected right under Section 7 of the Charter. It must be noted that this is not an absolute right and requires a balancing process so as to ensure that the right is not lightly disregarded and that any limitations of the right take into consideration the risk of harm to the patient and the risk of harm to the public. [...] The person found to be incapable loses autonomy over his decision making and to a large extent over his person.⁹⁰

The rights language used by the courts in statements such as these reflects the liberal democratic principle of the rule of law (Goonan, Healy and Moynihan, 2000).

Governmentality theorists note that a rights-based approach tends to mask the tendency of legal authorities to be dominated by medicine and to “rubber-stamp views expressed by psychiatrists” (Goonan, Healy and Moynihan, 2000, 24). The outcomes of these cases, wherein the determination of incapacity to consent is overwhelmingly upheld, tends to bear this out. According to Goonan, Healy and Moynihan,

Insofar as the mentally ill express noncompliant forms of consciousness, rights are withheld. Further, not only are rights not extended to them, but also it is the very individualizing of rights that makes it possible to

⁸⁹ *Kirpiev v. Peat* [2002] O.T.C. 488, par. 22.

⁹⁰ *Kirpiev v. Peat* [2002] O.T.C. 488, par. 31.

withhold them from the mentally ill. When rights have as a precondition of entitlement the adoption of the monitored, bourgeois self, the mentally ill as a category are denied them (2000: 29-30).

Once it is established that the patient lacks the capacity to self-monitor their mental condition, they are categorized as incapable of making self-directed treatment decisions. Their status as incapable removes their right to self-determination. This liberal view of the self, Fabris, argues, requires that the agent have the *capacity* to claim human rights, while leaving behind the voices of the marginalized (2006, 17).

Subverted discourse: Marginalized voices

The case law on capacity to consent to treatment consistently revolves around the subject's failure to have insight into their illness, failure to acknowledge the benefits of treatment and failure to make connections between treatment non-compliance and mental deterioration on one hand and treatment compliance and improved condition on the other. For K.T., failure to "see the connection between the lack of treatment and a deterioration in her ability to function"⁹¹ is considered evidence of incapacity. On the other hand, any acknowledgement on the part of patients of the risks and side-effects of medications is consistently subverted. Any insight into the manifestations of side effects and the conclusions reached by patients about the short-term and long-term effects of those side effects is minimized. Fabris expresses this subversion as a case of voices of "sound" minds being heard over the voices of "unsound" minds (2006, 13).

⁹¹ K.T., *Re*, 2004 CanLII 43054 (ON C.C.B.), www.canlii.com, accessed May 5, 2006

For example, in Thompson's case, her attorney argued that the Board failed to consider the issues she raised concerning the medications' side-effects:

The Appellant complains of adverse side-effects from her medication, namely pain at the site of the injection, excessive weight gain, excessive salivation, pain in her legs, trouble walking and fatigue. She had been taking the antipsychotic drug, clopixonol, and the drug Artane, to counteract the side-effects. She says that she has been free of medication since the last Treatment Order. She complains that she gained almost 50 pounds during her last hospitalization last year, when she received these drugs.⁹²

This testimony was dismissed because the Court argued that “[u]nlike Mr. Starson, who clearly recognized that he had mental problems, the Appellant steadfastly refuses to acknowledge that she has” any.⁹³ This failure to acknowledge her condition, in the eyes of both the Board and the Court, leads her to lack the ability to meet the second part of the test for capacity, that is, she is “unable to appreciate the reasonable foreseeable consequences of a decision or lack of decision regarding her treatment.”⁹⁴ Her evidence, however, since it emanates from the voice of an “unsound” mind, is considered unreasonable and is therefore discounted.

Even where evidence does indicate that the subject has an understanding or a degree of insight into their condition, it is often rejected. For example, in *E.S.*⁹⁵, in comparison to the “cogent, compelling and credible” evidence that she did suffer from a mental disorder offered by the psychiatrist, the Board noted that “Ms. E.S.’s understanding of the diagnosis was in the abstract and not as it pertained to her own mental health. In other words, she had the mental ability to understand the information but lacked the insight to

⁹² *Thompson v. Grant* [2001] O.T.C. LEXIS 315, par. 13.

⁹³ *Thompson v. Grant* [2001] O.T.C. LEXIS 315, par. 24.

⁹⁴ *Thompson v. Grant* [2001] O.T.C. LEXIS 315, par. 7.

⁹⁵ *E.S., Re*, 2004, CanLII 30068 (ON C.C.B.), www.canlii.com, accessed online May 3, 2006

recognize that it applied to her.”⁹⁶ That inability was apparently evidenced by her denial of the need for treatment and her failure to appreciate the probable consequences of non-treatment. In the words of the Board’s decision, “Ms. E.S. took the prescribed medication and met with members of the community treatment team only because of that Damoclean threat overhanging her and not because she recognized the need for treatment”⁹⁷ (referring to the threat of being re-institutionalized). At the hearing Ms. E.S. said the consequence of not taking the medication was that she would be “pulled into the hospital.” The record states that, “[s]he did not see a medical need for psychiatric medication and was concerned about the side effects, which included substantial weight gain, reduction in stamina, and loss of motivation.”⁹⁸ E.S., also referred to as Dr. S. because she had a medical degree, feared her prescription medication, Zyprexa, would cause her death due to a televised report about the drug. Despite her treatment compliance and legitimate health concerns, the patient was unable to convince the Board of her capacity to consent.

At another CTO hearing, Ms. L.M.’S psychiatrist insisted that “LM’s understanding of her illness does not always translate to taking steps in her ongoing daily living. It is more an intellectual process that does not translate into reality.”⁹⁹ The fact that she says she takes her medication automatically, the Board argued, suggests a lack of agency on her part, and therefore, her status as incapable of consenting was upheld. In this case, even

⁹⁶ *E.S., Re*, 2004, CanLII 30068 (ON C.C.B.), www.canlii.com, accessed online May 3, 2006

⁹⁷ *E.S., Re*, 2004, CanLII 30068 (ON C.C.B.), www.canlii.com, accessed online May 3, 2006

⁹⁸ *E.S., Re*, 2004, CanLII 30068 (ON C.C.B.), www.canlii.com, accessed online May 3, 2006

⁹⁹ *L.M., Re*, 2004 CanLII 51967 (ON C.C.B.), www.canlii.com, accessed May 5, 2006

where the subject is complying with the health duty by taking her medication, her motives for doing so and her capacity for agency are both questioned.

There are even cases where testimony presented by witnesses for the patients is rejected. In *Starson v. Swayze* (1999), the Board acknowledged that it had "largely discounted" the evidence provided by friends and colleagues of Professor Starson. The basis for rejecting this evidence was that those individuals did not have access to as much medical information as that available to the doctors, that their evidence was inconsistent with the other evidence before the Board, and the unlikelihood that any of them understood the legal test for capacity under the Act.¹⁰⁰ This is a compelling example of an institution of psycho-legal expertise making claims to "truth."

Furthermore, even where a patient was found capable of consenting, the *sincerity* of the testimony was placed in question, as evidenced in this statement from *R.R.*:

We found that RR was clearly a bright person. There was evidence in the various clinical records filed that Dr. Doan believed that as well. A concern we had centred on whether RR actually believed what he told the panel. We found no reason to discount his evidence. In our unanimous opinion Dr. Doan's evidence as to RR's incapacity seemed to center more on refusal to weigh consequences rather than ability¹⁰¹.

There is also evidence in the case law that there is a lack of full disclosure of the risks and benefits of treatment to patients. In the case of *H.R.*, the Board stated that it was not necessary to discuss the risks and benefits of treatment with a patient once the psychiatrist was of the opinion that the patient failed one part of the capacity to consent

¹⁰⁰ *Starson v. Swayze* (1999) 22 Admin L.R. (3d) 211, par. 25.

¹⁰¹ *R.R., Re*, 2004 CanLII 36179 (ON C.C.B.), www.canlii.com, accessed May 3, 2006

test. Even where the patient is found to have the ability to understand the relevant information, the psychiatrist believed it unnecessary to disclose the information, as this statement suggests:

Mr. McIver [counsel for H.R.] submitted that Dr. Grant's failure to have full discussions about the risks and benefits of treatment eroded the value of the finding that Mr. H.R. was incapable. We disagree. Capacity requires both the ability to understand relevant information and the ability to appreciate the reasonable foreseeable consequences of a treatment decision or lack of it. As Mr. H.R. did not have the latter ability, Dr. Grant did not have to prove he did not have the former.¹⁰²

In other words, the patient must prove they have the ability to "appreciate the reasonable foreseeable consequences of a treatment decision" without having those consequences disclosed to them. The Board's decision goes on to state, "Mr. H.R. could discuss the *risks* of treatment with pharmaceuticals but could not see any *benefit* to them" (my emphasis).¹⁰³

This lack of disclosure and tendency on the part of the psychiatric community to highlight the benefits of treatment to the exclusion of the risks is consistent with the universal consent principles set out in the U.N. *Principles for the protection of persons with mental illness and for the improvement of mental health care* adopted in 1991.

According to Gendreau, the U.N. instrument

provides the patient who refuses or wants to stop a treatment with a particular right to information: 'The consequences of refusing or stopping treatment must be explained.' Why is this kind of information only required when a person refuses or wants to stop a treatment? On the contrary, it should be part of the right to information included in the definition of informed consent. This provision shows an obvious tendency to presume that the refusal of treatment always and exclusively has negative effects and that the acceptance of treatment always and

¹⁰² *H.R., Re*, 2004 CanLII 30069 (ON C.C.B.), www.canlii.com, accessed May 3, 2006.

¹⁰³ *H.R., Re*, 2004 CanLII 30069 (ON C.C.B.), www.canlii.com, accessed May 3, 2006.

exclusively has positive effects. It implies that everything must be done to make those who refuse treatment change their minds (Gendreau, 1997, 272).

Our current understanding of mental capacity emerges from legal and psychiatric texts as sites of knowledge production. Out of the psycho-legal discourse emerges our knowledge about psychiatric subjects who are incapable of consenting and what that incapacity looks like. “Just as discourses exclude or marginalize some other discourses while empowering others, so sites of knowledge also subordinate other knowledge” (Hunt and Wickham, 1994, 13). What these case studies reveal is that the subjects’ knowledge and experience of their illness and relationships to medication is subverted as yet another symptom of their mental condition.

The judge in *Neto v. Klukach*, however, did acknowledge the Court’s tendency to dismiss patient’s evidence and the risk to autonomy posed by equating disorder with incapacity:

[T]he Board must avoid the error of equating the presence of a mental disorder with incapacity. People who have mental disorders are perhaps most at risk of having their personal autonomy overridden by the likely unconscious imposition of value judgments. It is easy to conclude that if a person chooses a course of treatment which appears to be reasonable and wise, then the person is capable; whereas, if a person chooses treatment that doctors consider to be contrary to the best interests of the patient, or even patently unwise, then the person is incapable. Those with mental illness are perhaps most vulnerable to having their experiences with reactions to medications and personal views regarding treatment options not taken seriously, but instead attributed to the mental illness itself, if contrary to what is considered conventional wisdom.¹⁰⁴

In turning to an emphasis on self-discipline in his later work, Foucault identified “subjugated knowledges” – “those knowledges that tend to be buried and disguised beneath more dominant, often more ‘scientific’ or ‘expert’ knowledges” (Lupton, 1997,

¹⁰⁴ *Neto v. Klukach* [2004] O.T.C. 138, par. 12.

104). The case law presented here suggests that the knowledge these psychiatric patients form with respect to treatment is readily subjugated. Their experiences and concerns with side effects are regularly dismissed as an effect of their delusional state.

When consulting a doctor, individuals may, on at least some occasions, and if they so choose, attempt to struggle against, challenge or subvert those disciplinary techniques they experience as restricting of their autonomy. That patients often fail to take 'doctors' orders' is evident in the extensive medical literature on the problem of patient compliance with medical regimes (Lupton, 1997, 105).

Lupton argues that the "good patient" seeks freedom from symptoms and disease not as a passive, docile patient but as an active health "consumer" (ibid.). By that criteria, the non-compliant psychiatric patient resisting their incapable status is by definition a "bad patient." That resistance, however, is part of the legal governance of the subject; it is never complete but part of the "attempt to control-failure-attempt to control" cycle (Hunt and Wickham, 1994).

In conclusion, what emerges from the Ontario's capacity to consent case law is that the risk of harm posed by psychopharmaceutical treatments is downplayed and patients' experiences of these risks rejected as a mere symptom of their condition. The benefits of these chemical treatments and the risks associated with treatment non-compliance are upheld as the "truth" – a "truth" the incapable subject is presumably unable to see through the lens of their disorder.

This dominant discourse details the boundaries of what "choices" the psychiatric subject is persuaded to make – treatment compliance or forced treatment compliance. Failure on

the part of the patient to meet the first obligation of self-knowledge – insight into their condition, entails the convergence of legal and psychiatric authority. The legal discourse here gives the appearance of arguing against conflating treatment refusal with incapacity, but where that refusal is said to be the result of a lack of insight, the end result for the patient is the same – a determination of incapacity.

A limit to the affinity between legal and psychiatric discourses again lies where psychiatric authorities rely on arguments of what is in the “best interests” of the patient. It is unclear, however, whether mention would be made of the existence of these best interest arguments had the patient in question not otherwise obviously met the legal criteria for capacity to consent.

Chapter Six: Duty Of Care, Right To Health And The Duty To Be Well

[T]he right to treatment predominates with health as a strong symbolic underlying value. This health value, I must underline, is exclusively reduced to a medical perspective and it implies, for the psychiatric patient, the obligation to be treated without due consideration of his or her capacity to consent to treatment (Gendreau, 1997, 276).

Gendreau highlights the value placed on health and how this is aligned with arguments for the *right to* treatment. This understanding of right to health pits the right to *refuse* treatment against the right *to* treatment. Within this discourse, the patient's refusal itself is seen as a "symptom of mental illness" and reason enough to *need* to treat (1997, 269). As I discussed in the previous chapter, the tendency to view treatment refusal as a symptom of illness is a feature of the psycho-legal discourse.

The tendency seemingly runs counter to our current neo-liberal form of governance; one which champions individual freedom, choice, autonomy and rights against patriarchal state intervention (Lupton, 1999). However, as I will argue in this chapter, subjects remain "intensely governed" (Rose, 1999a): political, economic, social and cultural forms of regulation continue to structure the field of possible actions from which subjects may "choose" (Otero, 2003).

One feature of neo-liberalism is that individuals are increasingly responsible for their own health outcomes. I argue that this "duty to be well" (Greco, 1993) extends to those diagnosed with psychiatric disorders as evidenced by the implementation of community treatment laws. These orders "compel medication compliance in the community under pain of involuntary psychiatric admission" (Szigeti, 2001, 25-26). As Brophy and

McDermott point out, in the wake of deinstitutionalization there has been an increasing concern regarding the apparent risks posed by people with mental health problems living in the community (2003). A response to this is to ensure that those individuals remain under the effects of psychiatric treatment (i.e., drugs), while living in the community. Critics of CTOs, however, argue they are methods of coercion, which erode patients' rights and are a way to circumvent the provision of effective public mental health services while forcing patients to take psychotropic medications associated with numerous side effects (O'Reilly, 2004). Psychiatric survivors have gone so far as to call CTOs a form of "chemical incarceration" (Fabris, 2006, 7).

The third matter considered in capacity to consent decisions, the goals and consequences of the proposed treatment, I argue, aligns the normative value of health with the patient's duty to be well. Forced treatment compliance, whether within the involuntary committal setting or in the community under a community treatment order, compels the patient to adhere to the dominant health value. As Greco observes, the notion of "health as a *right*" is replete with notions of "health as a *duty* of subordination to authority" (Greco, 2004, 2). The traditional paternalistic psychiatric discourse arguing for a right to treat those in need of treatment becomes a *duty* to be treated under Ontario's capacity to consent laws.

A contradiction inherent in neo-liberal doctrine becomes evident here. It is a myth that reduced state involvement, a key component of neo-liberal ideology, is actually achieved through policies that give the outward appearance of divestment. In the "roll-out" phase of neo-liberalism, new regulatory institutions are created (Keil, 2002, 581). Harris'

Common Sense Revolution, while exalting the virtues of a small, accountable government, was actually “highly interventionist.” One example of this intervention is the creation of community treatment legislation. By broadening the category of persons subject to compulsory psychiatric treatment and extending the territory over which legal governance of the incapable psychiatric subject could be exercised beyond the borders of bricks-and-mortar facilities, government intervention is effectively increased (Fabris, 2006). Meanwhile, public housing programs were “rolled back,” severely limiting the “space” for subjects of CTOs in the community while the Safe Streets Act, legislation designed to criminalize homelessness and panhandling was “rolled out” (Keil, 2002, 588).

What Ontario’s consent and capacity law suggests is that there has been a shift from the state’s duty to care for the patient, based on the concept of *Parens Patriae*, to the patient’s “duty to be well.” The state’s involvement is not reduced however, rather it shifts from that of care to that of enforced health. This shift is evident from the changes in the expressed goals of forced treatment and community treatment orders, as found in these cases. Where previous legislation and psychopharmaceutical limitations meant that the goals of treatment were the alleviation of symptoms and control of the patient’s behaviour within the confines of a psychiatric institution, CTO provisions combined with second-generation anti-psychotic medications shift the focus onto individual self-care. To be able to reintegrate into the community, and remain in the community rather than be institutionalized, the subject of the CTO must show the ability to care for their self by adhering to the treatment plan. Since the price to pay for non-compliance with the

treatment plan is re-institutionalization, the psychiatric subject does indeed have a *duty* to be well.

These goals remain in line with the psychiatric “right to treatment” discourse which states that, in theory, “the ‘serious and persistently mentally ill’ should, by chemical management of their symptoms, recover their reason and conduct themselves accordingly within society; responsibility confers rights” (Fabris, 2006, 46-47). Responsibility here is imposed through chemical restraint. While these goals imply that subjects recover their capacity for self-determination, the continued legal governance of incapable psychiatric subjects severely limits their field of possible choices of conduct.

The Duty of Care

Justice Misener, in *S. (N.) v. Norris*, commented on the dual purpose of the *Mental*

Health Act:

Essentially the *Mental Health Act* is concerned with two things. It is concerned with the rights of persons who, because of mental disorder, find themselves in attendance at a psychiatric hospital. It is concerned as well with society’s obligation to provide treatment to those patients for the mental disorders from which they suffer. These two concerns are not always in harmony.¹⁰⁵

The legislation thus seeks to balance individual rights with societal obligations of care.

That obligation is normally characterized in terms of providing a treatment, and, specifically, a chemical psychopharmaceutical treatment.

As an early example illustrates, the goal of ordering forced treatment for an incapacitated involuntary patient was to ameliorate and stabilize the patient’s condition.

¹⁰⁵ *S. (N.) v. Norris* (1992) 6 Admin. L.R. (2d) 228, par. 12.

The evidence showed that his condition was incurable. The attending physician obtained an order authorizing the administration of neuroleptic drugs and related medical treatment. The drugs had been found to have alleviated the symptoms of the appellant's condition, reducing the delusions and disturbed state resulting therefrom and enabling the appellant to function moderately well in a social context within the institution.¹⁰⁶

The goal of treatment is thus both medical and social. Through forced administration of neuroleptic medication, it is hoped the patient's condition will improve by alleviating the symptoms of disease. In the absence of these symptoms, it is argued, the patient will be unable to function in accordance with the norms of the institution.

Similarly, the stated benefits of treatment in Gallagher's case are described as bringing about a state of normalcy and a degree of dignity. The judge stated,

Kenneth Gallagher, I find, is suffering indescribable agony as an uncontrolled psychotic, isolated from the only world he has come to know, I have no hesitation in making the order requested to provide to him as much normalcy and dignity as possible, pending the outcome of the appeal, in the knowledge that the countervailing risks in his particular case, appear to be minimal.¹⁰⁷

The court ordered treatment pending appeal since the benefits of immediate treatment were found to outweigh the risk of harm to the patient. There was evidence that the medications had worked in the past by alleviating symptoms, allowing the patient to regain a level of autonomy by reducing the risks of harm to himself and to other patients and staff.

¹⁰⁶ *Fleming v. Reid* (1990) (head note)

¹⁰⁷ *Fleming v. Gallagher* (No. 1) (1990) 74 O.R. (2d) 317 (322 b)

Induced Capacity to Consent

With the *Starson* case, we see evidence of incapacity to consent determinations being used as a catalyst for *future* treatment compliance through the use of forced medication. The idea is that, under the effects of medication, the patient's mental condition will improve to the extent that they are indeed capable of forming valid consent and, at such time, will *choose* to consent to, and comply with, their treatment plan. In Starson's initial appeal from the Consent and Capacity's Board's finding of incapacity (1999), one treatment goal stated by Starson's psychiatrist was to induce treatment compliance. The strategy employed is one of getting Starson's brain activity to "normal" levels (through forced medication) so that he will be capable of treatment compliance. His psychiatrist also used the possibility of future release as a motivator for complying with treatment. Dr. Swayze hoped Professor Starson might agree to take the other drugs "if his psychosis would remit sufficiently" as a result of the injections, although this had never occurred before. Alternatively, he thought that Professor Starson might see the Ontario Review Board as a "serious motivator" and take the oral drugs as the intelligent option after a risk benefit analysis, even without insight into his illness.¹⁰⁸

The Superior Court Judge replied, "The Board was apparently of the view that unless Professor Starson receives the proposed medication, his likelihood of release by the Review Board would be diminished" (par. 24). Release is therefore used as a bargaining chip by the Board to secure treatment compliance. The question is, had Starson initially showed agreement to treatment, would his capacity to consent ever have come into question?

¹⁰⁸ *Starson v. Swayze* (1999) 22 Admin L.R. (3d) 211, par. 49.

The “Normalizing” Process

Starson’s psychiatrists also stated that the purpose of the proposed treatment was “normalization:” To “slow down” his thought processes to a “normal level range of mood and thought process without psychosis.” Although similar treatment had not worked in the past, they argued that this was because there had not been a long enough treatment period (par. 51).¹⁰⁹

Before the Court of Appeal, Starson stated:

Well, like all psychiatrists that I've met before them, they all think the same way, that the only thing they can do is to give you these chemicals - and I've been through these chemicals that they propose before - and I know the effects and what they want to achieve is to slow down my brain, basically, and to slow down my brain which means I can't do what I've been trying to do - or what I have been doing for 30 years and will be successful at doing. And that would just be like worse than death.¹¹⁰

The normalizing process is precisely what Starson rejects and resists, and, based on Starson’s ability to perceive the reasonable foreseeable consequences of the “normalizing” effects of the medication on his ability to perform his work as a physicist, the Supreme Court deemed

Professor Starson is entitled to make his own treatment decisions. He is not required to make his decision on a basis that the Board finds reasonable or wise. Nor is he required to adopt a lifestyle or way of thinking which accords with the Board's or the respondents' views of what is ‘normal.’¹¹¹

¹⁰⁹ *Starson v. Swayze* (1999) 22 Admin L.R. (3d) 211, par. 51.

¹¹⁰ *Starson v. Swayze* (2001) 146 O.A.C. 121, 201 D.L.R. (4th) 123, 33 Admin. L.R. (3d) 315, par. 12.

¹¹¹ *Starson v. Swayze* [2003] 304 N.R. 326 (SCC), par. 76.

When referring to bringing about a state of “normality” through medication, it is important to consider that norms of health are socially defined. These social norms result from heterogeneous practices of dominant knowledge, such as that of biomedical experts (Greco, 2004, 4). Starson actively resists these practices of dominance, yet his psychiatrists responded with several attempts of control, having challenged Starson’s capacity to consent through four levels of court.

Reducing the “Risk of Dangerousness”

In addition to its normalizing effects, forced treatment of incapable patients is associated with reducing risks, most notably, the risk of dangerousness. This treatment goal was stated in *Khan v. Thompson* (1992):

The availability of treatment which may reduce her dangerousness favours that custodial setting over the penitentiary system which lacks such measures and which can only respond to manifested or apprehended dangerousness by non-therapeutic corrective measures (311d).

In later cases, the reduction of risk is also a condition of returning to the community.

In *Kirpiev v. Peat*, we find the goal of reducing dangerousness, specifically reducing the risk that Kirpiev would become involved in criminal activity once released into the community:

The proposed treatment would decrease the paranoia and permit him to be more cooperative in his discharge planning as well as decreasing the risk that his aggressive state would lead to a criminal offence (par. 36).

In other cases, the “risk” associated with non-treatment is not clearly stated, although the goal of discharge in the community remains:

The goal of discharge held by the physician was in keeping with R.F.'s prior wish that he "be treated with the lowest practical dose that would get him well enough to be discharged from hospital..." (Par. 10). On the evidence that was before the Board, it was clear that R.F.'s current treatment was not working, and without some other treatment, his core delusions would remain and he would continue to be at risk if discharged from hospital (Par. 11).

R.F.'s prior capable wish was thus ignored in favour of a more progressive course of treatment towards achieving improved mental health and risk reduction.

Repeated references are made to patients being "at risk." The nature of that risk is often vague and unspecified. Being deemed "at risk" has become a means of social identification, and one need not be ill (yet) to be so labelled (Davidson *et al.* 1994, 355 cited in Nettleton 1997, 215). As Petersen points out, "the distinction between healthy and unhealthy populations totally dissolves since everything potentially is a source of 'risk' and everyone can be seen to be 'at risk'" (1997, 195). Additionally, failure to conduct oneself in a risk-free manner is seen as a failure of self-control and a failure to comply with citizenship obligations (Petersen 1997, 198). These obligations extend to all contemporary subjects within the realm of neo-liberal governance, not merely psychiatric subjects.

While "risk" is frequently referred to using the general term of being "at risk," in *Conway v. Jacques* (2005), we find a rare disclosure of the specific risk of suicide: "Dr. Jacques believes that if Mr. Conway is not treated, he will remain at Oak Ridge for the rest of his life, and will be at risk of suicide" (par. 28).

In his case, self-regulation is the treatment goal, but we also find the rarely cited goal of enabling the patient to take part in psychotherapy:

Dr. Jacques expects that psychotropic medications would substantially alleviate Mr. Conway's feelings of vulnerability and persecution, improve his capacity to regulate his affect and his ability to focus on constructive activities, and enable him to engage in long-term psychotherapies that might resolve his underlying issues (Par. 24).

Posing a risk to others is often "added on" to posing a risk to self such that the phrase "posing a risk of harm to self or others" becomes a blanket statement. In *Allihebi* (2001) for example, the judge agreed that the evidence presented suggested "he would pose a risk of harm to himself and others" (par. 12). Mr. Allihebi was described as having paranoid-type schizophrenia. He had been fasting because he heard voices from God telling him to do so. Consequently, he was near-death as a result of his refusal to eat or drink (par. 7-8). Although the risk of non-treatment was described as becoming a danger to self and others, no indications were given as to how he posed a risk to anyone but himself.

The case of H.L. is important for highlighting that findings of incapacity to consent to community treatment orders are not necessarily tied to a concern for public security. As this case suggests, actual *evidence* of past aggression and danger to others are not necessarily factors in the determination of capacity to consent. Mr. L had been diagnosed with treatment-resistant schizophrenia. He was described as abusing alcohol, cocaine and marijuana and is HIV and hepatitis A, B, and C positive, none of which is treated. He had been found not criminally responsible on an assault charge. On another occasion, he forcibly removed a child from its parents' arms, for which he was not charged. He has

been barred from boarding homes, the Mission Shelter and the Shepherds for Good Hope due to threatening and aggressive behaviour and, in the last case, for throwing a rock through a window.¹¹²

He was admitted to hospital after presenting himself to an emergency ward where “it was obvious to those who saw him there that he was not coping very well and was unable to comply with the CTO.” He was detained for a psychiatric evaluation and, in Dr. Spindler’s opinion, Mr. L was incapable of consenting to a CTO and, due to his non-compliance with treatment, he remains a danger to others if left in the community. Furthermore, he was unable to find a medical supervisor willing to be assigned to his treatment in the community.¹¹³

The case before the Board involves Mr. L’s challenge to Dr. Spindler’s finding that he was incapable of consenting to a community treatment order. Mr. L’s testimony before the Board made it clear that he was aware of his diagnosis and acknowledged that he suffers from a mental illness. He was also able to articulate the benefits of treatment and how his condition deteriorated without the treatment. He was therefore declared capable of consenting to a treatment plan. Therefore, no CTO was ordered and he remained a patient on a voluntary basis, free to go as he pleases.¹¹⁴

¹¹² *H.L., Re*, 2004 CanLII 15216 (ON C.C.B.), www.canlii.com, accessed May 3, 2006

¹¹³ *H.L., Re*, 2004 CanLII 15216 (ON C.C.B.), www.canlii.com, accessed May 3, 2006

¹¹⁴ *H.L., Re*, 2004 CanLII 15216 (ON C.C.B.), www.canlii.com, accessed May 3, 2006

A link has traditionally been made between criminality/dangerousness and mental illness.

Individuals with psychiatric disorders are thought to be more “dangerous” than the “average” citizen. However, as Anita Szigeti points out,

The myth of the dangerous mentally ill patient no longer requires serious debate within the professional community of our mental health system. It is clear that alcohol and substance abuse and many other factors, such as a prior history of criminal behaviour, or even age and gender, are more solid predictors of violence than a diagnosis of mental illness (Szigeti, 2001, LEXIS online publication).

Despite evidence to the contrary, the media portrayal of the dangerous psychiatric patient continues to fuel public fears. The naming of mental health legislation after the victims of crimes at the hands of the mentally ill serves to legitimize this belief. The law on community treatment orders was introduced, in part, as a means of reducing the risks posed by the mentally ill in the community; by creating a means by which the mentally ill would remain in the community only under the effects of medication. Although named after Ottawa sportscaster Brian Smith, killed by Jeffery Arenberg in 1997, two other incidents of that year are cited as the impetus behind community treatment order provisions being added to the *Mental Health Act*. Szigeti notes the media coverage of these events strongly suggested that these deaths would have been avoided had the patients been medicated (2001). Naming legislation aimed at ensuring the chemical control of patients with serious mental illness after rare incidents of violence perpetuates the public fear of the mentally ill as dangerous (O’Reilly, 2004, 583). Events such as these have lead Bassman to conclude that “emotionally charged rhetoric designed to incite and frighten the public is positioned through well-funded campaign strategies to make forced treatment the dominant answer to the mental illness problem” (2005, 489).

Goals and Benefits of CTOs

Not all of the decisions analyzed contained full details of the treatment plans. Based on the details provided, the treatment plans contained in community treatment orders vary in their degree of surveillance and control over the psychiatric subject. J.F.'s plan was not uncommon:

That Plan included provisions that JF continue taking anti-psychotic medications as prescribed and that she be monitored. JF was also to attend appointments with her psychiatrist and other follow up and support.¹¹⁵

No matter how comprehensive the plan, the message remains that they are “less restrictive than being detained in a psychiatric facility.” In commenting on Mr. E.S.’s plan, the Board notes,

[I]t allows Mr. E.S. to within reason live where he wants such as in his trailer in the summer and obtaining employment as he has with the Town of Penetanguishene. He has freedom to do what he wishes with his day provided he is taking his medication and symptoms of his illness are not exacerbating.¹¹⁶

Freedom is thus contingent upon psychiatric wellness through medication, improved self-care, social relations and increased civic involvement. “All active citizens have a right and a duty to maintain, contribute to and ensure [...] their health status” (Nettleton, 1997, 208). Incapable psychiatric subjects are no exception.

Improved self-care is key in the pronounced treatment benefits. However, as Petersen suggests, “[d]isagreement among experts means that there are rarely coherent sets of norms to which one may defer in caring for oneself” (Petersen, 1997, 201). For example, while the subject of a CTO, C.I. was described as “more aware of the need to care for

¹¹⁵ *J.F., Re*, 2004 CanLH 48658 (ON C.C.B.), www.canlii.com, accessed May 3, 2006

¹¹⁶ *E.S., Re*, 2005 CanLH 12685 (ON C.C.B.), www.canlii.com, accessed May 5, 2006

herself and lose excess weight. She was able to listen to the news and to be in touch with world events. She talked to her daughters at least daily.” However, she is also described as only going for groceries, not having contact with others, not having any friends, and, it is noted that she “talked about the side effects of medication, fatigue and lethargy in particular,” a behaviour which is problematized. These statements are contradictory and suggest that the psycho-legal authority of the Consent and Capacity Board has a particular ideal of behaviour the patient ought to comply with, but, disagreeing as they do amongst themselves makes this “ideal” particularly elusive for the subject compelled to negotiate this incoherent set of “norms.”

E.S. showed improved self-care and was able to secure supportive housing and a disability pension. She did some volunteer work for the elections. Ms. B.C. is described as requiring continuing treatment, care and supervision in the community. She was also taking part in community programmes and “exhibited better judgment” as a result of the CTO. The evidence in K.T.’s case “revealed Ms. T made wonderful progress with the support of the care team in her housing [...]. She demonstrated ‘organized and appropriate thought content generally without hallucinations or delusions’ and appeared happy, cooperative and willing to engage her roommates, the CTO staff and the staff at the housing unit where she resided.”¹¹⁷ These examples all point to the psycho-legal discourse on the benefits of CTO-enforced treatment compliance – improved self-care through treatment and supervision, secured housing, and civic involvement. Through this discourse an entrepreneurial psychiatric subject emerges – the subject remains

¹¹⁷ *K.T., Re*, 2004 CanLII 43054 (ON C.C.B.), www.canlii.com, accessed May 5, 2006

categorized as “incapable of consenting to treatment” yet is made to meet her entrepreneurial obligations through chemical regulation.

The duty to be well is linked to the duty to be free of risk; of risk of harm; risk of dangerousness. Security in these cases is a function of risk reduction. Regardless of a lack of evidence supporting the view that psychiatric patients are more dangerous than other members of the public, that risk of danger to others remains an argument for the forced treatment of incapable subjects. However, a patient’s insight into their condition, as evidenced by their ability to articulate the benefits of treatment and the risks of non-treatment, trumps the concern about future risk of harm, dangerousness and security breaches.

In the case of patients found to be lacking in capacity and thus the freedom of self-formation, coercive practices are still relied upon. This goes counter to the shift Foucault discusses in *Ethics: Subjectivity and Truth*. He states, “these games of truth no longer involve a coercive practice, but a practice of self-formation of the patient” (1997, 282).

While the goal of forced treatment may be to bring about a state of self-awareness in terms of insight into illness, self-care in terms of wilful treatment compliance and self-formation in terms of bringing the patient to a level of freedom and civility through psychopharmaceuticals, the practice of coercion in the form of community treatment orders and forced medication of incapacitated patients remains.

The goals of treatment expressed in the case law vary over time. Normalizing the patient through alleviation of symptoms within an institutional setting was the goal in the early days of capacity to consent legislation. With the advent of second-generation psychopharmaceuticals, deinstitutionalization, social rehabilitation and drug-induced treatment compliance became the goals. Since CTOs have been introduced, improved self-care in a supervised community setting has become the enunciated goal of treatment. Alongside this goal is that of reduced risk of deterioration of the patient's condition and the reduced risk of harm to self and others. This reduction of risk is frequently presented in terms of a reduced "risk of dangerousness" perpetuating the myth of the dangerous psychiatric subject. Problematizing the condition of the subject further legitimates the need to impose compulsory treatment, thereby overriding the subjects' right to self-determination. The therapeutic psycho-legal discourse calls for the forced chemical treatment of incapable subjects, whether those drugs themselves impose a danger or not (Bay, 2003). An intriguing contradiction arises where the danger of chemicals is downplayed while the idea of the dangerousness of the untreated psychiatric subject is perpetuated. The forced chemical treatment of the subject, as Fabris observes, suggests that the subject has a problem of the self which must be worked upon and that chemical treatment is the only responsible "choice" to make in this situation (2006, 147).

The "myth of dangerousness" associated with the mentally ill continues to be perpetuated by these judgments and the legislation behind them. Rather than being rejected, this argument is used to expand the scope of psycho-legal governance of the incapable psychiatric subject. Not only is the role of the "psy sciences" extended through risk

discourses by including the task of making future predictions of pathology, but the legal instruments for dealing with that role are also extended. The addition of community treatment order legislation gives legal authority, and further legitimates, the predictive role of the psychiatric expert.

Chapter Seven: Concluding Remarks

I began this thesis by introducing the significance of a psychiatric patient being found incapable of consenting to treatment. Patients such as these lose their legal right to self-determination and hence freedom to choose to accept or reject a proposed treatment. In this age of “freedom of choice,” it is important to challenge our commonly conceived notions of what that “freedom” entails. One way of investigating this dominant discourse on freedom is to examine examples of constraints imposed on freedom. I noted that strategies taken to determine and regulate incapacity claim to seek a balance between individual rights and public safety. However, I have also argued that recent legislative changes in the province of Ontario have expanded the scope of legal governance of incapable psychiatric subjects. Concerns over risks posed by community-based treatment have led to the “implementation of measures to increase the surveillance, supervision and support of discharged patient.” Among these were legal measures implemented to ensure treatment compliance (Goodwin, 1997, 262), namely, community treatment orders.

I could have explored other scenarios – being found incapable of consenting to medical treatment or procedures (a rising problem as our population ages), or incapacity to consent to admission to a care facility or to manage property. I chose the topic of capacity to consent specifically as it pertains to psychiatric subjects because mental illness itself remains problematized and highly discursive. The language governing our understanding of mental illness continues to be that of “*risk* and *danger*” (Blackman,

2000, 58-59). Furthermore, as Jeremy Laurance observed, in the aftermath of relatively rare occurrences of acts of violence perpetrated by discharged mental health patients, the “focus shifted from the care of the patients to the protection of the public. The psychopathic murderer – the mad axeman of popular myth – became the new monster in our midst. Risk avoidance and public safety became the new watchwords” (2003, xiii). The means by which a psychiatric patient comes to be declared capable or incapable of consenting to treatment designed to reduce their *risk* and *danger* is therefore an important area to research. This change in focus in mental health policy led me to put forward that the guiding principle behind capacity to consent law changed from that of the state’s “duty to care” to the patient’s “duty to be well.” By being found incapable of consenting to treatment, the patient becomes subject to enforced treatment compliance, whether within the involuntary committal setting or in the community under a community treatment order. The patient is therefore compelled to adhere to the dominant health value, but, furthermore, since treatment is argued to be a means of reducing “dangerousness,” enforcing treatment compliance is legitimated as a means of ensuring public security.

In the first chapter I mapped out significant changes in the legislative history of Ontario’s capacity consent laws. I argued that the contemporary legal history of mental incapacity emerged alongside our current neo-liberal form of governance. The contemporary notions of capacity to consent and the right to refuse psychiatric treatment show affinities to the production of the neo-liberal subject: one called upon to be a responsible, autonomous, entrepreneurial citizen. I also showed how the history of Ontario’s capacity

to consent to treatment laws highlights conflicting principles of neo-liberalism: The principles of autonomy and self-determination on the one hand, and the duty to be well on the other. Where autonomy rights have been extended to psychiatric subjects in the name of expanding freedom of choice, restrictions have also been placed on that freedom such that freedoms may only be exercised in line with the duties of a responsible, healthy citizen. Where neo-liberal doctrine calls for reduced state intervention, governance of the incapable psychiatric subject has actually multiplied. One strategy employed for expanding the control and surveillance of the psychiatric subject was the expansion of commitment criteria based on a series of potential “risks of harm.” Another was to include treatment incapacity as an additional commitment criterion. These changes, I argued, are a response to public fears over security risks posed by the psychiatric subject.

I have also shown that the history of capacity to consent law in Ontario is one of competing claims to authority between law and psychiatry. Throughout the history of capacity to consent law, legal restrictions on psychiatric practice have been resisted by psychiatric professionals eager to legitimize their authority and expertise over the realm of the psychiatric subject. In the end, law adopts the discourse of psychiatry as a means of placating public fears through the adoption of CTO legislation.

In chapter two, I briefly discussed the weakness of traditional theoretical approaches to capacity to consent and how I would attempt to go beyond their dichotomous assertion of power as either legitimate or illegitimate by adopting a genealogical approach. A genealogical approach to a topic, in this case, capacity to consent, considers the

“conditions of possibility” which give rise to a particular phenomenon, or, as Hunt and Wickham define it, “what combination of circumstances in dispersed and seemingly unconnected fields of social activity combines in such a way to give rise to some outcome” (1994, 6). Adopting this approach to the present study allows us to view capacity to consent law as a form of legal governance of psychiatric subjects. In doing so, I aimed to explore how mental capacity, as a legal and psychiatric concept, has developed alongside a particular route of social economy: the emergence of neo-liberalism.

I also discussed the “conditions of possibility” aligned with the emergence of neo-liberal doctrine according to governmentality theorists: political divestment, deinstitutionalization, assumptions of self-regulating entrepreneurial subjects based on theories of the “psy sciences,” and the proliferation of “risk” discourses. These strategies of governance have all produced regulatory effects and those effects are felt throughout society – this thesis examines one microcosm of those effects – the governance of psychiatric subjects.

In chapter three I discussed the importance of analyzing the discourse of capacity to consent as contained in capacity to consent case law: these legal decisions, I argued, contain textual evidence for how knowledge about incapable psychiatric subjects is produced. Since these texts result from an adversarial process, both dominant and counter discourses surrounding capacity to consent are presented. I argued that the

dominant discourse on incapacity to consent to psychiatric treatment would be aligned with the dominant form of political rationality, neo-liberalism.

I also explained how this study would follow from Hunt and Wickham's principles for analyzing law as a form of governance. This analysis of governance was particularly concerned with how knowledge (informed as it is by the "psy sciences") was used in legal deliberations and, ultimately, to reform the conduct of psychiatric subjects.

Chapters four, five, and six presented an analysis of the discourse contained in the legal judgments. I observed that the decision to overturn a psychiatrist's determination of incapacity essentially involved three questions: 1) the patient's insight into their condition, 2) the evidence of treatment effectiveness, and 3) the goals and consequences of treatment or lack of treatment. I approached each of these considerations in these three chapters.

The subject's ability to demonstrate insight into their condition was a key concern for court justices and Board members alike. I argued that this obligation was in line with the dominant psychiatric discourse on mental illness and that this discourse was adopted by legal authorities to the extent that inability to articulate insight on the part of the patient eroded any legal right to self-determination. I therefore observed that freedom was contingent upon insight. Showing insight resulted in the freedom to take risks by refusing treatment; treatment refusal is couched in terms of "risk" even where a subject is found capable of forming consent. Failure by the psychiatric subject to meet this

condition of freedom resulted in the imposition of the *obligation* to be healthy in line with the “duty to be well.” Insight, in these texts, was equated with capacities for self-knowledge and self-care, in other words, capacities of the entrepreneurial subject.

Legal and psychiatric discourses have historically been interconnected (Slovenko, 2004). That interconnection is apparent in the cases analyzed. The mere fact that the subject’s incapacity status was overturned in only eight of the forty-six cases points to the tendency of legal authorities to adopt the dominant psychiatric discourse. This finding goes counter to the tendency of psychiatric professionals to resist legal restraints on their practice. While legal authority is exercised over psychiatry in cases where psychiatric practitioners have clearly overstepped their boundaries, in the overwhelming majority of cases legal and psychiatric discourses converge in the legal governance of the psychiatric subject. I also noted that the emergence of new regulatory institutions in line with the exercise of governance by expertise is a feature of neo-liberalism (Smith, 1989).

Ontario’s Consent and Capacity Board, an institution of psycho-legal expertise, is, I argued, an example of a new regulatory body. Comprised of both legal and psychiatric experts, the Board exercises authority over all manner of questions of capacity to consent, yet, the infrequency with which the tribunal diverts from the original psychiatric findings points to the extent to which this combined regulatory institution aligns itself with the “psy” sciences. Since these “psy” sciences have been crucial in constructing both the ideal neo-liberal subject and the current form of governing, judgments rendered by the Board are hence aligned with neo-liberal rationalities.

In chapter five I analyzed how the second consideration, the efficacy of the proposed treatment, was examined. I observed that this involved weighing the risk of harm to self from side effects against the risk of harm to self, and, as a consequence, harm to others, from non-treatment. In keeping with Fabris's findings, the benefits of these chemical treatments are upheld in keeping with the brain-disease model and described in such a manner as to deny any challenge from patients (Fabris, 2006). Subjects' experiences with and concerns about these medications were routinely discounted. While legal challenges to the safety of these medications was evident in earlier judgments, justices ultimately sided in the psychiatrists' favour as long as the patient failed the insight test.

Benefits of newer, second-generation medications were used as a proverbial "carrot on a stick" to patients. Claims were made that if the patient complied with these treatments, they could eventually be considered for release. Refusal of treatment, given the claims made, was equated with incapacity – the patient *must* not have the ability to understand the consequences of their decision. This also points to one of the goals of treatment: release from a psychiatric institution (under the confines of a community treatment order) so that the subject may become self-governable.

Rose argued that the "at risk" discourse expands the role of the "psy" expert: predicting future pathology (1998). This expanded role was clearly evident in the judgments, since capacity to consent legislation began including "risk of harm" criteria. The Board went so far as to argue that the criteria for a CTO need not be met at the time of a CTO hearing; it was sufficient that the patient be "at risk" for meeting the criteria, in absence

of treatment, at a later date.¹¹⁸ While the Superior Court did object to this argument and overturn the decision, it is, never the less, an indication of the psycho-legal practice of predicting future pathology. Furthermore, while the Superior Court placed limitations on the use of the “at risk” discourse in the above case, that does not necessarily extend to the multitude of future Board decisions.¹¹⁹ The statement concerning CTOs as a response to the “revolving door syndrome” in Q.S.¹²⁰ is evidence of that:

Clearly, it is a purpose of a community treatment order to prevent the pattern in question from occurring in the future, if there is evidence that such might become the case. Assuming that to be a constant requirement, one must ask whether a finding of such a future risk can be made only on the basis of the number of admissions that have already occurred and the interval between them. If so, what is a sufficient number? What is an acceptable interval? However, in our opinion, the confirmation of a CTO does not depend on the existence of such a past pattern, nor is it necessary that one is likely to emerge in the future.¹²¹

What these cases ultimately revealed was that the psychiatric subjects’ experience of their illness and relationships to medication was subverted as yet another symptom of their mental condition. Because of this condition, it is argued, the patient is unable to see the “truth” about the benefits of these treatments and the risks associated with not complying with their treatment programs.

The goals of treatment, as found in these cases, have changed over time. Normalizing the patient through alleviation of symptoms within an institutional setting was the goal in the early days of capacity to consent legislation. These goals were, I argue, in line with a

¹¹⁸ *Haughan v. Whelan* (2003).

¹¹⁹ In 2005 alone, 1065 CTOs were issued for mentally ill people in Ontario---and they usually called for enforced medication (<http://www.cbc.ca/thecurrent/2006/200601/20060123.html> Accessed March 15, 2007).

¹²⁰ *Q.S., Re*, 2005 CanLII 7112 (ON C.C.B.)

¹²¹ *Q.S., Re*, 2005 CanLII 7112 (ON C.C.B.), www.canlii.com, accessed May 5, 2006

state's "duty to care." With the advent of second-generation psychopharmaceuticals, deinstitutionalization, social rehabilitation and drug-induced treatment compliance became the goals. It is hoped that, through medications, patients will achieve a level of functioning where they can govern themselves. Under the constraint of CTOs, reduction of "risk" is key: reduced risk of harm to self and others. This reduction of risk is frequently presented in terms of a reduced "risk of dangerousness," thus perpetuating the myth of the dangerous psychiatric subject.

Two important points need to be made concerning contradictions inherent to neo-liberal doctrine which are made more apparent through this analysis of the legal governance of the psychiatric subject. First, the introduction of community treatment orders has extended the possibility of forced treatment outside the traditional boundaries of involuntary institutions. Rather than reducing the role of the state in mental health affairs, this move has actually increased government intervention (Fabris, 2006; Keil, 2002). Secondly, while the legislation states that this is a means of providing treatment in the least restrictive environment, it is also clearly aligned with broader neo-liberal strategies by placing the onus on the individual and by having the individual be responsible for their own psychiatric health and risk reduction through enforced treatment compliance. Where the psychiatric subject has gained "freedom" in the sense of living in the community, that subject still remains "intensely governed." Furthermore, they must align their freedom within the purview of very constrained "choices" lest they find themselves locked behind institutional walls once again.

While this study has laid the groundwork for an analytics of capacity to consent law as a form of legal governance of psychiatric subjects there are areas of research that could expand upon this knowledge. First and foremost would be a gender analysis of capacity to consent decisions. It has been argued that women are over-represented and over-medicated as psychiatric patients (Busfield, 1996). There exists an entire history of discourse surrounding women's "irrationality" and madness (ibid). Furthermore, in only one of the forty-six cases analysed was a woman's designation of incapacity overturned. This suggests a gender bias exists in findings of capacity to consent. The language used in the legal decisions to describe the risks associated with treatment non-compliance also seems to suggest different decision criteria were at work for men and women. For example, alienation and homelessness associated with treatment non-compliance under a CTO were problematized more so for women than for men. A wider sample of CTO decisions and a corresponding theoretical discussion would be required to fully investigate capacity to consent law as a site of production of gendered subjectivity.

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APPENDIX A – CASES ANALYZED

SUPREME COURT OF CANADA

1. *Starson v. Swayze* [2003] 304 N.R. 326 (SCC)

ONTARIO COURT OF APPEAL

2. *Fleming v. Gallagher* (No. 1) (1990) 74 O.R. (2d)
3. *Fleming v. Reid and Gallagher* (1991) 4 O.R. (3d) 74
4. *Khan v. St. Thomas Psychiatric Hospital* (1992) 7 O.R. (3d) 303
5. *Starson v. Swayze* (2001) 146 O.A.C. 121, 201 D.L.R. (4th) 123, 33 Admin. L.R. (3d) 315
6. *Barnett v. Hamilton Psychiatric Hospital* (2002) ONCA C38466
7. *Conway v. Jacques* (2002) ONCA C36001
8. *Chen v. Hillen* (2005) ONCA 9323
9. *Thompson v. Grant* [2005] CanLII 14965

ONTARIO SUPERIOR COURT / DISTRICT COURT

10. *Clark v. Clark* (1982) 40 O.R. (2d) 383 (Ont. Co. Ct.)
11. *Re T and Board of Review for the Western Region* (1983) 44 O.R. (2d) 153
12. *Howlett v. Karunaratne* (1988) 64 O.R. (2d) 418 (Dist. Ct)
13. *Fleming v. Reid* (1990) 73 O.R. (2d) 169
14. *S. (N.) v. Norris* (1992) 6 Admin. L.R. (2d) 228
15. *D'Almeida v. Gojer* [1999] 104 O.T.C. 326
16. *Roy v. Furst* 1999 O.T.C. LEXIS 732; 1999 OTC Uned. 333

17. *Starson v. Swayze* (1999) 22 Admin L.R. (3d) 211
18. *Duarte v. Kingston Psychiatric Hospital et al.* (2000) O.T.C. LEXIS 1100, 2000 OTC Uned 896
19. *Allihebi, Re*, [2001] O.T.C. 587
20. *Gunn v. Kocerginski* [2001] O.T.C. 839
21. *Thompson v. Grant* [2001] O.T.C. LEXIS 315
22. *Kirpiev v. Peat* [2002] O.T.C. 488
23. *Boimier v. Swaminath* [2003] O.T.C. 644
24. *Sousa v. Klukach* [2003] ONSC 03-20/02
25. *Neto v. Klukach* [2004] O.T.C. 138
26. *R.F. v. Colleton* [2004] O.J. No. 218 ON.C. LEXIS 314
27. *T.S. v. O'Dea* [2004] O.T.C. 18
28. *Conway v. Jacques* [2005] ONSC 2939
29. *Lefebvre, Re* (2005) CanLII 27012 (ON S.C.)
30. *Malcolm v. Packer* [2005] O.J. No. 1635; 2005 ON.C. LEXIS 1858

COMMUNITY TREATMENT ORDERS

31. *C.I., Re* (2002) CanLII 33965 (ON C.C.B.)
32. *B.C., Re* (2003) CanLII 41627 (ON C.C.B.)
33. *E.S., Re* (2003) CanLII 46968 (ON C.C.B.)
34. *Haughan v. Whelan* (2003) CanLII 37606 (ON S.C.), (2003) 63 O.R. (3d) 713
35. *E.S., Re* (2004) CanLII 30068 (ON C.C.B.)
36. *H.L., Re* (2004) CanLII 15216 (ON C.C.B.)
37. *H.R., Re* (2004) CanLII 30069 (ON C.C.B.)
38. *J.F., Re* (2004) CanLII 48658 (ON C.C.B.)
39. *K.T., Re* (2004) CanLII 43054 (ON C.C.B.)
40. *L.M., Re* (2004) CanLII 51967 (ON C.C.B.)
41. *R.R., Re* (2004) CanLII 36179 (ON C.C.B.)
42. *C.O., Re* (2005) CanLII 12684 (ON C.C.B.)
43. *E.S., Re* (2005) CanLII 12685 (ON C.C.B.)
44. *Q.S., Re* (2005) CanLII 7112 (ON C.C.B.)
45. *Thompson v. Grant* (2005) CanLII 374 (ON S.C.)
46. *W., Re* (2005) CanLII 24582 (ON C.C.B.)