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Restraint to facilitate treatment: Is it compatible with least restraint principles?

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In a 2008 decision, ***S.M.T. v. Abouelnasr***,[2] the Superior Court of Ontario (Canada) considered for the first time whether restraint could be construed as "treatment" under the *Health Care Consent Act* ("HCCA"). The case was an appeal by S.M.T., an involuntarily admitted psychiatric patient who had applied to the Consent and Capacity Board ("CCB") for a review of his involuntary status and capacity to consent to treatment. When the CCB confirmed both matters, the patient appealed the decisions to the Superior Court. On appeal, the patient challenged the constitutionality of the use of restraints for the purpose of administering treatment to incapable persons, on whose behalf a Substitute Decision Maker ("SDM") had consented.

History of case

By way of background, the patient had been involved in a serious motor vehicle accident in 1987.[3] As a result, the patient acquired a brain injury, which in turn gave rise to a significant change in personality, a Psychotic Disorder and cognitive impairment. Since the motor vehicle accident, he had had several contacts with various psychiatric facilities.

In 2001, the patient was charged with several criminal offences, in relation to which he was found unfit to stand trial. As a consequence, he was ordered detained at a forensic psychiatric facility and subject to annual review by the Ontario Review Board.

In November 2005, the patient's then attending psychiatrist had determined he was incapable with respect to treatment with anti-psychotic medication, mood stabilizers and anti-depressants. This determination was confirmed by the CCB on November 28, 2005. The decision was not appealled and a member of the patient's family began to act as his SDM. In February 2006, the patient was acquitted of the criminal charges following a *prima facie* inquiry under s. 672.33 of the *Criminal Code*. At that point, the SDM consented to his continued admission at the facility (so that he then became what is referred to as an informal patient).

During the informal admission, the patient was treated pursuant to the SDM's consent with some clinical improvement in his condition noted. In June of 2007, a new attending psychiatrist assumed care of the patient. He determined that the patient remained incapable with respect to anti-psychotic medication. Due to the patient's non-compliance with the oral anti-psychotic medications and consequent deterioration, the physician also determined that the patient would benefit from a long-acting anti-psychotic medication to be delivered intramuscularly by injection. The SDM's consent to the treatment was obtained and a consent form was signed.

The consent form confirmed that the SDM has also consented to:

> "such additional diagnostic or treatment procedures which, in the opinion of the staff providing the above-noted treatment, are considered incidental to the procedure or immediately necessary and vital to the patient's health and/or life."

When the patient was advised that the SDM had consented to the IM injection, he became aggressive and threatening towards staff. It was determined that the patient could not be continued as an informal patient and his status was changed to involuntary, as provided for in the *Mental Health Act*. The same day, the attending physician administered an intramuscular injection of anti-psychotic medication. Due to the patient's forceful resistance to the medication, he was restrained during the administration of the treatment.

A week later, the patient applied to the CCB to review his involuntary status and the finding of incapacity. Prior to the date agreed to for the CCB hearing, the patient's involuntary admission was renewed as required by the timelines mandated by the *Mental Health Act*. The patient also received a second injection of medication, which was consented to by his SDM, as no new treatment had been commenced prior to the application to the CCB. The patient was restrained for the second injection.

The CCB confirmed that the patient met the criteria for involuntary admission as at the time of the hearing, and also confirmed the incapacity finding. The patient appealed the CCB's decision, and added two grounds of appeal:

- Whether the patient's constitutional rights were violated by the physician when he administered the intramuscular injections of medication under the SDM's consent; and

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- Whether the HCCA infringed certain sections of the Charter in so far as that legislation permitted the injection, under restraint, of anti-psychotic drugs for the purpose of treating incapable persons. [4]

The Court Decision

As the appellant had raised constitutional issues, the Attorney General of Ontario was provided with notice of the constitutional challenge and obtained leave to intervene to defend the legislation.

The Court first considered the appeal on the merits of the primary issues raised; that is whether the CCB had erred in finding that the patient was incapable with respect to treatment and in finding that the criteria for an involuntary admission had been met at the time of the hearing. The judge found that the Board's decision on these two issues was reasonable and did not allow the appeal on those grounds.

The judge then went on to consider the appellant's argument that the *Health Care Consent Act* provisions which permit the forcible injection of anti-psychotic drugs into incapable persons infringed section 7, 12 or 15 of the Canadian *Charter of Rights and Freedoms*.[5]

Ultimately, the Court held that the scheme set out in the HCCA for the administration of treatment to incapable persons under substitute consent provides sufficient procedural safeguards to protect the rights of incapable patients, as guaranteed by Canadian *Charter of Rights and Freedoms*.

In particular, the Court held that the definition of "treatment" in the Act, which includes "anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose" [6], includes by necessary implication the use of restraints, if necessary to administer treatment safely to incapable persons, provided that his or her substitute decision maker has consented to treatment. Madam Justice Lack wrote:

> "Since where substitute consent is obtained, treatment may be administered without the personal consent of the patient it is a necessary implication that a health care professional may have to restrain the person in appropriate circumstances in order to administer non-consensual treatment safely. Thus the use of restraint is something for a health related purpose." [7]

The judge, citing *Fleming v. Reid*,[8] confirmed that the forcible injection of anti-psychotic drugs into one's body on a non-consensual basis engages a person's interests under section 7 of the *Charter*, particularly the right to security of the person; and that any legislation that authorizes such treatment "must comport with the principles of fundamental justice." [9]

In *Fleming v. Reid*, the Court of Appeal had considered the legislative scheme of substitute decision making in force at that time. Under sections of the *Mental Health Act* since repealed, a Review Board could authorize the forcible treatment of an incapable person, over the objection of a substitute decision maker who was in good faith complying with a prior competent wish as required by the same legislation. The Court of Appeal held that such a scheme violated section 7 of the *Charter*.

The judge in *S.M.T.* noted that the HCCA (enacted some five years after the C.A. decision in *Fleming v. Reid*) sets out rules to guide SDMs in making decisions on behalf of incapable persons, as well as other procedural and substantive safeguards for patients who have been found incapable with respect to treatment. In the result, the judge found that the scheme in the HCCA that governs substitute decision making for incapable patients, including the application of restraint to facilitate treatment of incapable persons; was constitutionally sound and did not violate the Charter under either section 7, 12 or 15. 10

Where do health care providers go from here?

The restraint of psychiatric patients, incapable or otherwise, is understandably a subject of concern to healthcare providers, incapable patients and their SDMS, whether the patient is admitted to a psychiatric facility or in the community. As Justice Robins wrote in *Fleming v. Reid*:

> The right to determine what shall or shall not, be done with one's own body, and to be free from non-consensual medical treatment, is a right deeply rooted in our common law. This right underlies the doctrine of informed consent. With very limited exceptions, every person's body is considered inviolate, and accordingly every competent adult has the right to be free from unwanted medical treatment. [11]

In addition, the enactment of Ontario's *Patient Restraints Minimization Act* ("PRMA") in 2001, as well as a recent Coroner's Inquest that reviewed the circumstances surrounding the death of a forensic psychiatric inpatient while under restraint, [12] has focused attention on creating a culture of least restraint in the provision of health care generally in various settings.

It is important to note that the PRMA does not apply to persons involuntarily detained in psychiatric facilities under the MHA. (13) While certain provisions of the MHA provide for the detention and restraint of persons who meet the criteria for a Form 1 assessment and patients who meet the criteria for an involuntary admission, the Act is clear that nothing ***in the Act*** authorizes the restraint or detention of an informal or voluntary patient. [14] In other words, health care providers must look elsewhere for the authority to restrain patients who are not involuntary patients.

The HCCA, in addition to providing rules for determining capacity and substitute decision making, expressly preserves the common law duty of a healthcare provider to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or others. [15] In the mental health care context, this common law duty has been resorted to in emergent situations requiring, as the provision suggests, "immediate action." Addressing the refusal of medication by an incapable patient, where the treatment has been consented to by an SDM, generally does not require the kind of immediate action contemplated by the common law duty (although it may in certain circumstances). It is in the non-urgent situation, where the treatment team anticipates difficulty in engaging the incapable patient's cooperation with

treatment, that the *S.M.T.* decision is likely to be most helpful to mental health care providers.

It is generally acknowledged that patients should be encouraged to participate in treatment decisions, whether the patient is capable or not, and consequently, the decision to restrain an incapable patient in order to facilitate treatment under substitute consent may seem counterintuitive to that therapeutic impulse.

The 2008 *S.M.T.* decision allows health care providers to consider and plan for the restraint of the incapable patient, as may be required, in order to facilitate the safe administration of non-consensual treatment, lawfully consented to by an SDM. (16) It is instructive to return to the underlying purposes of the HCCA, as Madam Justice Lack did in her reasons for decision, and note that they include not only promoting the auonomy of capable persons, but also "protecting the welfare of persons who would benefit from treatment, but who are incapable of giving consent." [17]

References

1. Barbara Walker-Renshaw is a partner in the Health Law Group at Borden Ladner Gervais LLP. Ms. Walker-Renshaw represented the respondent physician, Dr. Abouelnasr, in the appeal that is the subject of this case comment.
2. [2008] O.J. No. 1298 (S.C.J.) [hereinafter cited as *S.M.T.*].
3. The facts set out in this section are taken from the publicly available Reasons for Judgment, *supra* note 2, and in the exhibits that were filed at the Consent and Capacity Board hearing, thus forming part of the record of the appeal.
4. *S.M.T.*, *supra* note 2, at para 11.
5. Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act* 1982 (U.K.), 1982, c. 11; Section 7 of the Charter guarantees that a person's interest in "life, liberty and security of the person" shall not be infringed unless such infringement is in accordance with the principles of fundamental justice; Section 12 guarantees a person's right to free of cruel or unusual treatment; and Section 15 guarantees a person's right to equal benefit of and equal protection under the law, without discrimination
6. *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sch.A, s. 2.
7. *S.M.T.*, *supra* note 2, at para 53.
8. (1991) 4 O.R. (3d) 74 (Ont. C.A.)
9. *S.M.T., supra* note 2, atpara 54.
10. *Ibid*., at paras 56 – 65.
11. *Fleming v. Reid, supra* note 8.
12. Inquest into the death of Jeffrey James; verdict October 10, 2008. Recommendations available at: http://www.mcscs.jus.gov.on.ca/stellent/groups/public/@mcscs/@www/@com/documents/webasset/ec070944.pdf
13. *Patient Restraints Minimization Act*, S.0.2001, s. 2(2): "This Act does not apply in circumstances in which the Mental Health Act governs the use of restraints on patients or other persons in psychiatric facilities."
14. *Mental Health Act*, R.S.O, 1990, c. M.7, s. 14.
15. *HCCA, supra* note 6, s. 7.
16. *S.M.T., supra* note 2, at para. 53.
17. *Ibid*, at para 57; see also *HCCA*, supra note 6, at s. 1.

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