Meds on the Menu: The Covert Administration of Psychotropic Medication to Adult Inpatients Determined to be Decisionally-Incapable in Ontario’s Psychiatric Settings

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy

Dalla Lana School of Public Health
University of Toronto

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ABSTRACT

Drawing on the fields of human rights and public health, this research explores the covert administration of medication: the concealment of medication in food or drink so that it will be consumed undetected. Adopting a rights-based approach, it explores multiple understandings of the impact of the practice on inpatients’ rights-experiences. Relying on critical approaches, it also explores the practice’s underlying socio-political-legal structures. The common themes of policies, protocols or guidelines that govern its practice in Ontario are identified. Focus groups and individual interviews were held with three groups of stakeholders (nurses, legal experts and psychiatrists), relying on fictional clinical scenarios.

Few policies, protocols or guidelines govern the practice in Ontario’s psychiatric settings. The practice impairs access to knowledge by patients and substitute decision-makers. It also precludes healthcare practitioners’ access to information about side effects and underlying reasons for medication refusal. It may interfere
with therapeutic relationships and patients’ meaningful recovery as they transfer from hospital without knowledge of the fact of the covert medication. It may be characterized as autonomy restoring since patients may become capable of making treatment decisions after having received the medication surreptitiously. Covert medication reflects an inflexible approach to capacity determination; it is distinguishable from approaches that imagine capacity as able to be fostered with support. It is primarily concerned with the management of “risky” inpatients in the short-term. The practice relies on a faith that medication will be effective, deferring to medical decision-making. While covert medication is understood to have “something to do” with rights, there is confusion about how those rights play out on the ground. Institutional silences underlie and reinforce the practice.

This research will support the development of effective, safe and appropriate approaches to treatment non-adherence that maximize patient dignity. Most pressing, this research concludes that the covert administration of medication warrants an overt discussion.
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CHAPTER 1: INTRODUCTION

This research focuses on a grey area of psychiatric practice and, as with other challenging practices, the law is called upon to navigate conflicting legal issues. While Courts have affirmed the centrality of informed consent in the receipt of health care, right to health arguments may be invoked to support the use of deception in psychiatric settings. This research explores the role and application of the law where the values of freedom and protection collide.

When a person who has been determined to be incapable of making treatment decisions refuses to comply with her medication regime, a health care practitioner (HCP) might consider addressing medication adherence in one or more of the following ways:

- physically restrain the person and deliver the medication by intramuscular injection or by suppository.¹
- offer rewards or inducements, including increased social activities², cigarettes³ and financial incentives,⁴ or make access to housing contingent on treatment adherence.⁵
- apply “chemical restraints” to manage medication compliance.⁶

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⁵ John Monahan, Alison Redlich, Jeffrey Swanson, Pamela Clark Robbins, Paul S Appelbaum, John Petrila, Henry Steadman, Marvin Schwartz, Bath Angela & Dale E McNiel, “Use of Leverage to Improve Adherence to Psychiatric Treatment in the Community” (2005) 56 Psychiatric Serv 37.
• work with the patient to identify underlying reasons for treatment resistance (including side effects) and possibly reach out to the patient’s substitute decision maker (SDM), to determine whether to re-assess the patient’s capacity.
• conceal medication in food or drink without the patient’s knowledge, and with or without explicit consent from the SDM.\textsuperscript{7}

This research focuses on the last practice. The “covert administration of medication” is the administration of medication in food or drink so that it will be consumed undetected by the person receiving it.\textsuperscript{8} A rights-based approach to understanding the practice of covert administration of medication in psychiatric settings is used. The multiple understandings of the rights impact of the covert administration of medication, including the structures that enforce its practice, are examined. While this research adopts a rights-based approach, it is also does so from a critical perspective, emphasizing how rights are expressed.

This chapter identifies the context, rationale and focus of this research. It also highlights the significance of the covert administration of medication to the disciplines of public health, public mental health and public health law. Finally, this chapter offers an outline for the balance of the dissertation.

I. LANGUAGE

Covert medication is variously known as “concealed medication,” “surreptitious prescribing” or “medication by subterfuge.” Each term attaches different value to the practice. This research employs the term “covert administration of medication” since it is most commonly applied to the practice. It is acknowledged, however, that this term is

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\footnotesize
witnesses a combative patient being placed into restraint and forcibly medicated must admit that it is a frightening exercise of power. Similar behaviour in other settings might well be viewed as battery.”
\end{flushleft}


\textsuperscript{8} McCullough, Coverdale & Chervenak (2007), \textit{supra} note 7.
not value-free.

Additionally, the term “patient”, rather than terms such as “client” or “consumer/survivor” will be used. Limiting, however, is that the term “patient” does not apply to the practice of the covert administration of medication in the family home. As set out in “Statement of Focus” below, the covert administration of medication in the family home is beyond the scope of this research. Instead, this research focuses on the rights-experience of psychiatric inpatients. The term “patient” is chosen because it is most reflective of the disparities of power in psychiatric institutions.

Where possible, this dissertation employs the term “persons with mental health issues” to include persons who have not accessed the psychiatric system (because of barriers to entry, for example) and have not been labelled as having a psychiatric diagnosis.

This research avoids the use of the term “competent” and prefers the term “capable.” The term competent carries a strong judgment, suggesting lack of intelligence. Ontario legislation, including the Health Care Consent Act and the Substitute Decisions Act, uses the term “capable.”

II. CONTEXT

In Ontario, the last forty years have seen the closure of major psychiatric institutions.\(^9\) Despite the promise of deinstitutionalization, community-based services remain under-funded and over-subscribed. Following deinstitutionalization, inpatient units in Ontario were understaffed and community-based supports were under-resourced.\(^10\) Gable and

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Gostin (2009) posited that deinstitutionalization has led to an “explosion in the number of mentally disabled people who have become homeless without any access to health services.”\footnote{Lance Gable & Lawrence O Gostin, “Mental Health as a Human Right” (2009) Ill Swiss Human Rights Book 249 at 252.} Many fall through the cracks after being discharged from the hospital only to end up in the justice system.\footnote{Ted Frankel, “Exodus: 40 Years of Deinstitutionalization and the Failed Promise of Community-Based Care” (2003) 12:1 Dalhousie J Legal Stud 1.} This revolving door between jail, hospital and the community means that more people end up in hospital in crisis.\footnote{Petrila & Swanson (2011), supra note 9 at 143: “Visible homelessness and the perceived dangerousness of people with mental illness, coupled with the increasingly costly problem of revolving door admissions of “noncompliant” patients to state psychiatric and community hospitals, helped to fuel a movement to adopt outpatient commitment laws throughout the U.S.”} Inpatient units in psychiatric settings are crowded, understaffed and hectic. In a high-pressure, stressful workplace, health care providers may feel compelled to rely on tools like the covert administration of medication to ensure patients take their medications.\footnote{Susan Welsh & Martin Deahl, “Covert Medication – Ever Ethically Justifiable?” (2002) 26 Psychiatric Bull 123.}

The covert administration of medication to a person who is capable of consenting to treatment is a clear violation of the provisions of the Health Care Consent Act, exposes the practitioner to criminal charges of battery, false imprisonment or fraud, and may violate the practitioner’s professional responsibilities. On the other hand, covert medication administration raises complex legal, ethical and clinical issues where the person is incapable of making a particular treatment decision. While the substitute decision-maker must consent to the treatment, it is unclear whether the substitute decision-maker must also consent to how that treatment administered.\footnote{Psychiatric Patient Advocacy Office, Info-Guide: Covert Medication (Medication Hidden in Food or Drink) (Toronto: 2009, PPAO).} The question of specific consent to the route of administration is under-litigated and is an example of the legal nuances raised by the practice.

Commentary on the practice of covert administration of medication is divided. Some critics challenge the limitations of patient autonomy, while others condemn the covert
administration of medication as overly paternalistic and an “unethical shortcut.” Others suggest that the practice may be acceptable in limited situations, including if the person is incapable of making treatment decisions. Some HCPs and family members justify the practice as a way to improve the care of persons with mental health issues.

Several specific clinical and treatment issues arise from the practice of the covert administration of medication. For instance, a person covertly receiving medication will be unable to report on the medication’s side effects. Instead, HCPs must rely on less reliable sources of information regarding the effectiveness of the medication. Additionally, delivering medication by crushing tablets or opening pills, without consulting a pharmacist, may cause adverse drug reactions. Some medications include instructions (i.e., do not crush) from the manufacturer or pharmacy. The covert administration of medication may also harm the trust relationship between the health practitioner and the patient (if its fact is discovered) and may interfere with help seeking and engagement with mental health supports and services. Since the fact of the covert administration may not be revealed to inpatients after discharge, covert medication may also deny a patient the “opportunity of gaining insight.”

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21 Aaron Levin, “Covert Drug Administration: Win Battle, But Lose War” (2005) 40 Psychiatric Serv 10: “Force and trickery only reinforce the sense of loss of control that mental patients often feel.”

22 Whitty & Devitt, supra note 17.
Interventions like psycho-education and de-escalation techniques may minimize the use of restrictive intervention measures\textsuperscript{23}, including covert medication.

Apart from institutional guidelines, no legal sources directly govern the covert administration of medication to adults in psychiatric settings who are determined to be decisionally incapable.\textsuperscript{24} Canadian legislation is silent on the question of covert administration of medication, and case law offers little comment. Moreover, professional guidance offers little support to health care practitioners. These legislative and policy silences contribute to the indeterminacy of its practice and lend additional justificatory support to its examination.

**III. STATEMENT OF FOCUS AND EXCLUSIONS**

This research focused on the covert administration of medication to adult inpatients determined to be incapable of consenting to treatment. This research focuses on its practice in Ontario, given that the laws that govern consent and capacity are within the provincial jurisdiction. This research also focuses on the practice in inpatient psychiatric settings. HCPs are usually responsible for the administration of medication in inpatient settings, while HCPs in outpatient programs do not usually take on this role.

This research focuses exclusively on the administration of medication by HCPs, rather than on the covert administration of medication by family members.\textsuperscript{25} In this way, the research explores the professional obligations of HCPs relevant to the practice of the covert administration of medication.

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\textsuperscript{23} Dennis C Donat, “Encouraging Alternatives to Seclusion, Restraint, and Reliance on PRN Drugs in a Public Psychiatric Hospital” (2005) 56: 9 Psychiatric Serv 105.

\textsuperscript{24} Erick K Hung, Dale E McNiel & Renee L Binder, “Covert Medication in Psychiatric Emergencies: Is it Ever Ethically Permissible?” (2012) 40:2 J Am Acad Psychiatry Law 239 at 244: “We are aware of no statutes in the United States that explicitly address or authorize the practice of covertly administering medications in psychiatric emergencies”

For the purposes of this research, covert medication does not include the practice of crushing pills in medication where the only reason for doing so is because the patient has difficulty swallowing.

This research does not examine the practice of covert medication in emergency settings because the legal context governing its practice in emergencies is distinct from its practice in non-emergency settings. For instance, section 25 of the Health Care Consent Act provides exceptions to the general requirements for consent.

This research does not consider the administration of medication to persons with developmental or intellectual disabilities unless they are also inpatients in psychiatric settings. A separate political and legislative regime governs the administration of developmental services in Ontario, making comparisons between systems difficult. This research excludes covert administration of medication to children. While issues raised by the practice in pediatric settings are not as contentious as those raised by the practice for adults they, nonetheless, deserve further, but separate, consideration.

The research excludes consideration of the practice in long-term care (LTC) settings. A separate legislative structure (including the Long-Term Care Homes Act [LTCHA]) governs these settings. The protection against abuse and neglect are included within the Residents’ Bill of Rights. The LTCHA expressly provides that abuse includes emotional abuse, financial abuse, physical abuse, sexual abuse and verbal abuse. The Regulation provides that physical abuse includes “administering or withholding a drug for an inappropriate purpose.” Given the differences between the governance of medication

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27 Long-Term Care Homes Act, SO 2007, c. 8 [LTCHA].
28 LTCHA, supra note 27 at ss 3(1.2 and 3(1.3).
29 LTCHA, supra note 27 at 2(1).
30 Long-Term Care Homes Act, O Reg 79/10 [LTCHA Regulation] at s 2(1). “Physical abuse” means, subject to subsection (2), (a) the use of physical force by anyone other than a resident that causes physical injury
IV. Research Questions

This study aims to understand how laws and policies are interpreted and expressed, relying on the example of the covert administration of medication to treatment-incompliant adult inpatients of psychiatric settings who have been determined to be incapable of making treatment decisions. The following questions will be addressed:

1. What are the common themes of institutional policies, clinical protocols or practice guidelines that apply directly or indirectly to the covert administration of medication?
2. What is the understanding of (1) legal experts, including patient advocates and ex-patient advocates, (2) nurses with inpatient psychiatric nursing experience and, (3) psychiatrists of the impact of covert administration to the rights-situation of incapable adult inpatients in psychiatric settings?
3. What socio-political-legal structures underlie the practice of the covert administration of medication to adult inpatients in psychiatric settings?

V. Public Health Significance

Clearly, there is more to public health than the application of medical technologies and the tracking of emergent diseases. Well-being is the primary concern of modern public health and includes more than “treatment” (and may include freedom from coercive treatment). Mann (1997) put it this way:

or pain, (b) administering or withholding a drug for an inappropriate purpose, or (c) the use of physical force by a resident that causes physical injury to another resident.

31 Institute Of Medicine, The Future of Public Health, (Washington: Committee for the Study of the Future of Public Health - Division of Health Care Services, 1988). At 7, the IOM “defined the mission of public health as fulfilling society's interest in assuring conditions in which people can be healthy.”
An exploration of the meanings of dignity and the forms of its violation — and the impact on physical, mental and social wellbeing — may help uncover a new universe of human suffering, for which the biomedical language may be inapt and even inept.  

This research draws on the twin fields of human rights law and public health. The fields of human rights and public health are complementary. Their combined attention emphasizes the well-being, equal respect and the preservation of dignity of all members of the community. Public health law research on mental health has a long history of interdisciplinary collaboration. Mann (1997) described both fields as necessary, arguing that the combination of the two advances human well-being beyond what could be achieved through an isolated health or human rights-based approach. Nixon and Foreman (2008) remarked on the “conceptual synergy” of an approach that combines the frameworks of human rights and public health. Indeed, Mann (1997) characterized public health and human rights as “allies.”


Lawrence O Gostin, Public Health Law: Power, Duty, Restraint (Berkeley: University of California Press, 2008) at 23: “Social justice thus not only encompasses a core commitment to fair distribution of resources, but also calls for policies of action that are consistent with the preservation of human dignity and showing of equal respect for the interests of all members of the community.”


Mann (1997), supra note 32 at 10: “Public health work requires both ethics applicable to the individual public health practitioner and a human rights framework to guide public health in its societal analysis and response.”


Mann (1997), supra note 32 at 9: “Modern human rights, precisely because they were initially developed entirely outside the health domain and seeks to articulate the societal preconditions for human well-being,
Public health policy should seek the optimal synergy between health and human rights, building on the premise that the optimal quality of a public health policy is attained when the highest possible health outcome and the fullest realization of human rights are both attained.40

Public health and human rights approaches share a focus on context, including societal factors; although, public health does not deal directly with those factors. Even though public health began as a social movement, it sought to provide individuals with information and education about risks associated with diet, smoking and the use of contraceptives.41 Mann (1997) argued that “public health lacks a vocabulary with which to speak about and identify commonalities among health problems experienced by very different populations.”42 Furthermore, according to Mann (1997),

...[M]odern human rights, precisely because they were initially developed entirely outside the health domain and seeks to articulate the societal preconditions for human well-being, seem a far more useful framework, vocabulary and form of guidance for public health efforts to analyze and respond directly to the social determinants of health than any inherited from the past biomedical or public health traditions.43

Law is a tool “for intervention to promote healthier places and people.”44 Legal

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41 Mann (1997), supra note 32 at 8.
42 Mann (1997), supra note 32 at 8.
43 Mann (1997), supra note 32 at 9. But also see Lawrence O Gostin, “A Vision of Health and Human Rights for the 21st Century: A Continuing Discussion with Stephen P Marks” (2001) 29 JL Med & Ethics 140 at 140: “But the field of human rights, like ethics, has an equally strong individualistic tradition that stresses free expression, association, privacy, and liberty. Even in the health context, human rights often has focused on medicine and de-emphasized public health. For many, the right to health has meant, almost exclusively, an entitlement to personal medical care.”
scholarship in public health has linked human rights law and legal practices to health.\textsuperscript{45} Burris, Kawachi and Sarat (2002) posited that public health law is itself a social determinant of health since the law contributes to the creation and perpetuation of other social determinants of health.\textsuperscript{46} Gostin (2008) defined public health law:

Public health law is the study of the legal powers and duties of the state, in collaboration with its partners (e.g. health care, business, the community, the media and academe), to ensure the conditions for people to be healthy (to identify, prevent and ameliorate risks to health in the population), and of the limitations on the power of the state to constrain for the common good the autonomy, privacy, liberty, proprietary and other legally protected interests of individuals. The prime objective of public health law is to pursue the highest possible level of physical and mental health in the population, consistent with the values of social justice.\textsuperscript{47}

Public health law research is the study of “the relation of law and legal practices to population health.”\textsuperscript{48} In \textit{Mental Illness, Law, and a Public Health Law Research Agenda}, Petrila and Swanson (2010) reviewed the state of the literature on the law’s impact on people with mental health issues. They compared the application of public health law to the experience of persons living with HIV/AIDS, tuberculosis and mental health issues.\textsuperscript{49} Petrila and Swanson (2010) identified common themes of public mental health law

limitations of health agencies.”


\textsuperscript{46} Burris, Kawachi & Sarat, \textit{supra} note 45 at 510. See also 521: “Because the ‘law is all over,’ it is a promising vehicle for change from the bottom up and from the top down.”

\textsuperscript{47} Gostin (2008), \textit{supra} note 34 at 4.


\textsuperscript{49} Petrila & Swanson (2010), \textit{supra} note 35 at 16: “In short, the use of coercion to gain access to care and/or to protect the public is not confined to people with mental illnesses but is a tool used in other public health contexts.” They continued at 46: “Mental health is an integral part of public health, and law applied to the population with mental illnesses is largely comprised of the same legal principles, put to the same ends, as public health law. This means that a public health law research agenda can include questions arising from legal efforts to shape and mediate public health outcomes for people with mental illnesses.”
research including legal efforts to expand the autonomy of persons with health issues through the use of advance directives.\textsuperscript{50}

Human rights frameworks have recently been applied to questions of public mental health, including towards the articulation of a right to mental health. For instance, Agus (2012) argued that the “interplay of law and mental health is a key factor affecting public health.”\textsuperscript{51} As such, the right to mental health should incorporate both individual and population-based approaches.\textsuperscript{52} Gable and Gostin (2009) elaborated on that distinction:

An individualized concept of mental health emphasizes the conditions most relevant to the mental health status of a particular individual. ... Public mental health, on the other hand, approaches issues of mental health from a population-based perspective. Under this approach, the state must not only provide care and rehabilitation services, but also must assure the existence of multiple conditions in which people can be mentally healthy.\textsuperscript{53}

\textsuperscript{50} Petrla & Swanson (2010), supra note 35 at 28: “Are legal efforts to expand autonomy for people with mental illnesses, such as psychiatric advance directives, broadly adopted, and if so, do they result in access to care more closely aligned with the person’s wishes?”

\textsuperscript{51} Deborah Agus, “Mental Health and the Law” in William Eaton, ed, Public Mental Health (Oxford: Oxford Scholarship Online, 2012) at 351: “The interplay of law and mental health is a key factor affecting public health and the development of systems to prevent and treat mental illness.”

\textsuperscript{52} Lawrence O Gostin & Lance Gable, “The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health” (2004) 63 Md L Rev 20 at 111: “The right to mental health contains two equally important components- the right to individual mental health and the right to public mental health. An individualized concept of mental health emphasizes the conditions most relevant to the mental health status of a particular individual. This individual concept predominates most of the discourse related to human rights. Protecting the individual’s interest in autonomy or liberty is the basis for most civil and political rights. Certain components of social and economic rights focus on the individual as well an affirmative right to health can be construed to apply directly to the mental health care needs of a specific individual. If the government knowingly implements policies and practices that are harmful to the mental health of individuals, there may be a violation of the right to individual mental health. Similarly, if the state withholds services necessary to maintain the mental health of individuals, it may violate that same right. By contrast, public mental health approaches issues of mental health from a population-based perspective. The human rights community has increasingly come to recognize the synergies between human rights and population health. Thus, it is interesting and timely to conceive of human rights from the perspective of the needs of populations as opposed to individuals.”

\textsuperscript{53} Gable & Gostin (2009), supra note 11 at 258: “Public mental health imposes a duty on the state, within the limits of its available resources, to assure the conditions necessary for people to attain and maintain mental health, including by providing decent economic conditions, education and health information, opportunities for meaningful employment, social and welfare services, primary and secondary mental health care, community mental health services, and hospital-based treatment and services. Governments
Nevertheless, mental health’s place in public health has only recently been recognized.\textsuperscript{54} Emergent public mental health trends include community integration initiatives for persons with mental disabilities in order to “provide persons with mental disabilities effective treatment in a community setting and to maximize opportunities for social integration.”\textsuperscript{55} Other pressing questions include scrutiny of the legal frameworks that restrict access to firearms for persons with mental health issues.\textsuperscript{56}

\textbf{i) State Power including Use of Coercion and Restraint}

The covert administration of medication raises questions about the authority of the state (and its actors) to constrain an individual’s autonomy to accept or reject treatment. Gostin (2008) characterized the power of government to “tax, inspect, regulate, and coerce” as necessary to “defend the common welfare”\textsuperscript{57} or to “achieve a common good.”\textsuperscript{58} Public health law must consider how to achieve a just balance between human rights and the state’s duty to protect and promote the public’s health.\textsuperscript{59} In a section devoted to the

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\textsuperscript{54} Petrina & Swanson (2010), \textit{supra} note 35 at 3: “While mental illness contributes a substantial burden of disease worldwide, it is only recently that its place in public health has been widely recognized... Given that mental health has often been an afterthought in discussions of public health, it is not surprising that many consider mental health law to be separate from, rather than part of public health law. However, the legal strands that make up this purported body of law are only occasionally applied uniquely to people with mental illnesses and are usually rooted in legal principles applied to general public health issues.”

\textsuperscript{55} Gable & Gostin (2009), \textit{supra} note 11 at 257: “The right to mental health, together with other human rights, supports modern trends in mental health policy and practice such as community integration initiatives for persons with mental disabilities and the newer concept of public mental health.”

\textsuperscript{56} Petrina & Swanson, (2011) \textit{supra} note 9 at 149ff.

\textsuperscript{57} Gostin (2008), \textit{supra} note 34 at 10: “Protecting and preserving community health is not possible without constraining a wide range of private activities that pose unacceptable risks.”

\textsuperscript{58} Gostin (2008), \textit{supra} note 34 at 11: “Public health powers can legitimately be used to restrict human freedoms and rights to achieve a collective good, but they must be exercised consistently with constitutional and statutory constraints on state action...Health regulations that overreaches, in that it achieves a minimal health benefit with disproportionate human burdens, conflicts with ethical considerations and is not tolerated in society based on the rule of law.”

\textsuperscript{59} Gostin (2008), \textit{supra} note 34 at 11: “Achieving a just balance between constitutionally protected rights and the powers and duties of the state to defend and advance the public’s health poses an enduring problem for public health law.”
public health issues relevant to persons determined to be “incompetent,” Gostin (2008) elaborated:

A decision to find someone incompetent can have far reaching consequences because it justifies fundamental control over their lives. It is for this reason that decisions about incompetence need to be made whenever possible using a formal legal process characterized by impartiality and fundamental fairness.\(^{60}\)

In their review of public mental health law, Petrila and Swanson (2010) characterized Gostin’s “power/duty/restraint” framework as “nicely framing issues at the core of the application of law to people with mental illnesses,” including “the reach of state power to coerce people into care; the duty of states to provide care; efforts to assure voluntary access to care; and the use of law to protect individuals and the public from dangerousness.”\(^{61}\)

In particular, this research considers justifications of the use of coercion or deception to ensure medication adherence. The covert administration of medication also invokes overlapping concepts of risk and resistance. Treatment non-adherence is conceptualized as “dangerous.” A person who resists medication is conceived as needing to be “managed” and, as such, this research considers the role that the law plays in that management. Relying on critical accounts of disability, the research considers the construction of the authority of persons with mental health issues to consent to or reject treatment.

\(^{60}\) Gostin (2008), *supra* note 34 at 50.

\(^{61}\) Petrila & Swanson (2010), *supra* note 35 at 6.
ii) Population Focus

Population health practices — including population mental health practices — are designed to improve the health status of populations, or groups within that population. Public health research includes the collection, analysis and interpretation of data for the purposes of determining patterns of health and health inequities. Freedman (1995) described the attention that public health pays to the patterns of health and disease:

Public health focuses on the links between an individual and the environment (physical, social-cultural, political, and/or economic) in which she lives, seeking in that linkage both an explanation for her health status and a potential entry point for policies and programs to address it.\(^\text{62}\)

Population health approaches recognize the importance of a contextual focus, rather than observing health behaviours in isolation. They are premised on the understanding that multiple factors, at both the individual and collective level, influence population health status and health inequities. For instance, population health approaches address the impact of the determinants of health, encouraging upstream investments in order to address the root causes of health and health inequities.

Like public health’s emphasis on the determinants of health, rights-based approaches draw attention upstream, towards an understanding of how contexts shape our experience of the law. For example, the Law Commission of Ontario (LCO) adopted a human rights approach to understand the civil, political, economic and social determinants of law’s impact.\(^\text{63}\) The LCO premised the development of the Framework for the Law as it Affects Persons with Disabilities on the “[r]ecognition of the broader social and environmental contexts of the experience of disability, and how they may


affect the ways in which persons with disabilities encounter the law.”\textsuperscript{64} Chapter 2 ("Theoretical Framework") elaborates on the application of the LCO’s Framework to the issues raised by the covert administration of medication.

By relying on public health and human rights frameworks, this research goes beyond the enumeration of the impact and influence of the practice on individual HCPs and patients. By focusing on the policies and laws that govern the practice, this research does not focus on the experience at the individual level. Instead, this research emphasizes the systematic and contextual structures that determine and influence the decision to covertly medicate. This macro-level focus is characteristic of the study of public health, which is concerned with broad strategies (including legal strategies) to ameliorate disadvantage and promote wellbeing.

\textbf{iii) The Centrality of Social Justice, including the Health of Marginalized Communities}

Social justice is at the centre of public health practice and theory.\textsuperscript{65} For Faden and Powers (2008), social justice principles provide the moral foundation of public health practice and “bringing about health is a specific objective of social justice.”\textsuperscript{66} Gostin (2008) argued that, as seen through the lens of social justice, the central aim of public health is to “advance human well-being by improving health and to do so particularly by focusing on the needs of the most disadvantaged.”\textsuperscript{67} He clarified this assertion:

\textsuperscript{64} LCO, \textit{supra} note 63 at 2.


\textsuperscript{66} Ruth R Faden & Madison Powers, “Health Inequities and Social Justice: The Moral Foundations of Public Health” (2008) 51:2 Bundesgesundheitsbl - Gesundheitsforsch - Gesundheitsschutz 151 at 152. Also at 153\textit{ff}: “Put another way, for public health as for justice, groups matter. Social justice is not only a matter of how individuals fare; it is also about how groups fare relative to one another whenever systematic disadvantage is linked to group membership. Depending on the context, the groups of particular concern may be defined by different characteristics such as gender, ethnicity, race, religion, caste, citizenship, sexual orientation, tribe, or disability. Whatever the common characteristic, the members of the disadvantaged group are accorded less social respect which frequently translates into reduced self-respect, reduced expectations, and reduced capacity for self determination.” [emphasis added]

\textsuperscript{67} Gostin (2008), \textit{supra} note 34 at 21. Gostin continued at 22: “Seen through the lens of social justice, the central mission of the public health system is to engage in systematic action to ensure the conditions for
The critical questions at the intersection of public health and justice are what people in society are most vulnerable and at greatest risk, how best to reduce the risk or ameliorate the harm, and how to fairly allocate services and benefits.68

The field of modern public health is interested in the equitable distribution of social and economic resources.69 Similarly, a human rights approach supports the development of a mental health system that provides equality of opportunity for people to enjoy the highest attainable level of mental health. It requires that persons with mental health issues enjoy equitable access to a system of appropriate and effective mental health supports and services.70 Faden and Powers (2011) asserted “self-determination is the core element of well-being” and that public health must be concerned with the ability to exert substantial control over one’s life.71

This research raises critical questions at the intersection of public health and human rights, including the vulnerability of people with mental health issues to exclusion, marginalization and loss of dignity. Even though one in five Canadians will experience a

improved health for all members of the population, and to redress persistent patterns of systemic disadvantage.”

68 Gostin (2008), supra note 34 at 22.


70 See, for example, the work of the Mental Health Commission of Canada (MHCC) which adopts a population-level approach to mental health: Mental Heath Commission of Canada, Changing Directions, Changing Lives: The Mental Health Strategy for Canada (Ottawa: Mental Health Commission of Canada, 2012) at 11: “Reducing the impact of mental health problems and illnesses and improving the mental health of the population requires promotion and prevention efforts in everyday settings where the potential impact is greatest.” See also 35: “Consistently upholding the rights of people living with mental health problems and illnesses is an integral part of fostering recovery and well-being. Barriers that can contribute to discrimination against people living with mental health programs and illness and hinder their full and effective participation in society must be eliminated. These barriers can be rooted in people’s attitudes and behaviour, in the ways in which programs and institutions are organized, or in the ways in which our schools, workplaces and other everyday environments are structured.”

71 Ruth Faden & Madison Powers, “A Social Justice Framework for Health and Science Policy” (2011) 20 Cambridge Q Healthcare Ethics 596 at 599: “In our twin-aim theory, the focal concern of self-determination is the ability of a person to exert some substantial, although not perfect or complete, control over her or his path through life. A self-determining life requires social conditions that can ensure that an individual is not merely the instrument of the will of others, or of social forces that she has had no role.”
mental illness during their lifetimes, the public health issues that affect persons with mental health problems remain under-explored. Agus (2012) illustrated the vulnerability of persons with mental health issues: “Mental illness is virtually the only disease category under which a diagnosis alone, rather than commission of a criminal act, may result in confinement, a massive curtailment of liberty.” As set out by the Supreme Court in R v Swain, persons with mental health issues “have suffered from historical disadvantage, have been negatively stereotyped and are generally subject to social prejudice.” The Supreme Court in Nova Scotia (Workers’ Compensation Board) v Laseur also found that “[t]he mentally ill have historically been the subjects of abuse, neglect and discrimination in our society.” Indeed, Patel and Bloch (2010) described the “appalling neglect of human rights” owed to people with mental health issues as “one of the greatest public health scandals of our times.” Gable and Gostin (2009) agreed:

Persons living with mental disabilities often face substantial obstacles to improving their mental health and participating fully in their communities and societies. They have been subjected to discrimination, stigmatization, and other indignities, including involuntary confinement without fair process, inability to access needed care and treatment, and the erection of social and economic barriers that limit their opportunities.

Like other public health research, this research contemplates broad-based interventions to improve the well-being of members of marginalized and excluded communities, including the development of effective and appropriate approaches to treatment resistance that maximize patient dignity. Medication refusal can be understood as a public health issue and is common in psychiatric settings. Morken and others (2008) reported that non-adherence to antipsychotic medication by community-based

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73 Agus, supra note 51 at 363.
74 R v Swain, [1991] 1 SCR 933 (Lexum) at 994.
75 Nova Scotia (Workers’ Compensation Board) v Laseur, [2003] 2 SCR 504 (Lexum) at para 90.
76 V Patel & S Bloch, “The Ethical Imperative to Scale Up Health Care Services for People with Severe Mental Disorders in Low- and Middle-income Countries” (2009) 85 Postgrad Med J 509 at 509.
77 Gable & Gostin, supra note 11 at 249.
outpatients was associated with relapses and hospital admissions.\textsuperscript{79} Owiti and Bowers (2010) emphasized that “[m]edication refusal is at the center of conflict and containment in psychiatry.”\textsuperscript{80} Petrila and Swanson (2011) considered public health’s “tools of leverage” to support medication adherence in community mental health settings.\textsuperscript{81} Ultimately, appropriate responses – with an eye to recovery - to treatment refusal contribute to better mental health.

iv) Engaging Questions of the Nature and Value of Rights

The law can be a powerful weapon for public health.\textsuperscript{82} It can be an essential tool\textsuperscript{83} as reflected by the constitutional maxim \textit{Salus Populi Suprema Lex} (“the health of the people is the supreme law”).\textsuperscript{84} The language of law (“rights,” “duties” and “justice”) animates current debates about public health.\textsuperscript{85} Agus (2012) claimed that the evolution of modern public mental health is “fundamentally intertwined” with the law.\textsuperscript{86} Chief Justice McLachlin considered the law’s role in population mental health:

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\textsuperscript{79} Gunner Morken, Jan H Widen & Rolf W Grawe, “Non-adherence to Antipsychotic Medication, Relapse and Rehospitalisation in Recent-Onset Schizophrenia” (2008) 8 BMC Psychiatry 32 at 32: “Non-adherence was associated with relapse, hospital admission and having persistent psychotic symptoms. Interventions to increase adherence are needed.”


\textsuperscript{81} Petrila & Swanson (2011), \textit{supra} note 9 at 140: “In the context of community-based management of mental illness and disability, treatment non-adherence and discontinuity are critical problems that contribute to poor long-term outcomes in the affected populations and may in some cases increase risk to public safety. Accordingly, new tools of “leverage” are being used in the legal and social welfare systems in an effort to engage people in treatment; the underlying assumption is that treatment over time will reduce rehospitalization, involvement in the criminal justice system, and risk to the public. These tools of leverage include outpatient civil commitment, mental health courts and jail diversion programs, specialty probation, subsidized housing programs, representative payeeship for disability benefits, and psychiatric advance directives.”

\textsuperscript{82} Robyn Martin, “A Brief Introduction to ...Public Health Law”(2009) 129:5 Perspect Public Health 200.

\textsuperscript{83} Gostin (2008), \textit{supra} note 34 at 4: “Law can be an essential tool for creating conditions to enable people to live healthier and safer lives.”


\textsuperscript{85} Gostin (2008), \textit{supra} note 34 at 23, “...the most important social debates about public health take place in legal forums – legislatures, courts, and administrative agencies – and in the law’s language of rights, duties and justice.”

\textsuperscript{86} Agus, \textit{supra} note 51 at 352.
\end{flushright}
Laws cannot heal people, only services and treatment provided by medical professionals can achieve that ultimate goal. But the law can create a social and regulatory environment that assists medical professionals in delivering their services in a manner that is both ethical and respectful of the rights and needs of persons with mental illness.\(^87\)

Despite law's utility, there are “fault lines” between civil liberties and public health.\(^88\) Law has enjoyed only limited success guaranteeing universal access to care for persons with mental health issues (including in the community) and, according to Petrila and Swanson (2011), law is usually better at “codifying standards for using coercion and other forms of leverage in efforts to induce treatment adherence.”\(^89\) To respond to these challenges, the Institute of Medicine called for additional public health legal research, including the “evaluation of the health effects and costs of legislation, regulations, and policies before and after implementation.”\(^90\) Public health law scholars, including Gostin (2008), remain hopeful that the fields are reconcilable:

Law reform, of course, cannot guarantee better public health. However, by crafting a consistent and uniform approach, carefully delineating the mission and functions of public health agencies, designating a range of flexible powers, and specifying the criteria and procedures for using those powers, the law can become a catalyst, rather than an impediment, to reinvigorating the public health system.\(^91\)

The covert administration of medication engages questions of the nature and value of

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\(^{88}\) Gostin (2008), supra note 34 at 26. See also Gostin & Powers (2006), supra note 65 at 1055: “Public health powers encroach on fundamental civil liberties such as privacy, bodily integrity, and freedom of movement and association.” See also Gostin (2001), supra note 43 at 140: “… we live in a society that values rugged individualism and distrusts government.”

\(^{89}\) Petrila & Swanson (2011), supra note 9 at 155: “A fundamental issue in creating community care systems is assuring universal and voluntary access to care, a task the law has approached with only limited success. Paradoxically, perhaps, law has been much better at codifying standards for using coercion and other forms of leverage in efforts to induce treatment adherence.”

\(^{90}\) Institute of Medicine, For the Public’s Health: Revitalizing Law and Policy to Meet New Challenges (Washington: The National Academies Press, 2011).

\(^{91}\) Gostin (2008), supra note 34 at 29.
“rights.” This dissertation considers how multiple understandings of “rights” or “law” influence the decision to covertly administer medication as well as how the law (or “rights”) is expressed in an everyday sense in an example of a difficult area of psychiatric practice. The focus here extends beyond an uncritical enumeration of different takes on a controversial practice. Rather, an understanding and contextualization of the meaning of rights, especially in an “on the ground” sense in psychiatric settings, is offered. As such, the approach taken here departed from scholarship that asks the question “what is the law?”

Moreover, covert administration also raises questions about the expression of law where rights conflict. On one hand, capable patients must enjoy a right to make decisions about their own bodies; while, on the other hand, patients also have a right to health. As a therapeutic agent, the medication administered covertly may act to restore a person’s autonomy, allowing her to make future independent decisions. However, family members and friends can support patients to make their own capable decisions, challenging the legal presumptions that value independence over interdependence. Health care providers have professional obligations that may conflict with the duty of the care setting to provide safe and secure environments. Petrila and Swanson (2011) characterized the conflict this way:

Some of these tools are overtly coercive, while others seek to maximize individual autonomy and choice. Due to public perceptions regarding the dangerousness of people with mental illnesses, most policymakers assume that social control must be available to mental health clinicians acting in concert with legal authorities. At the same time, with the ascendant belief that patient-centered care is essential to recovery, most consumers (as well as policymakers and treatment providers) now assume that patient autonomy is a critical value. The inherent tension between these twin concerns – the individual’s freedom and right to self-determination versus the exigencies of social control to manage public risk – creates a challenge for constructing social policy regarding the treatment of persons with mental illness at the
population level, as well as for making clinical decisions at the individual level.92

This research aims to reconcile critical accounts of the law — including of its indeterminacy — with Gostin’s (2008) characterization of the law as a tool, useful to support the public’s health, including mental health. The covert administration of medication is an example of a “grey area” of psychiatric practice. Patients are incapable of making treatment decisions but are also “treatment incompliant”, capable of expressing their (allegedly incapable) wish to refuse medication. Discomfort at these outer edges may be especially conspicuous where the person determined to be incapable experiences an episodic disability as is the case with some types of mental health issues.

VI. Roadmap

Because the covert administration of medication is covert, the practice remains under-theorized, under-researched and under-litigated. This practice has rarely been described. Fears of professional censure likely inhibit public debate about the covert administration of medication.93 Furthermore, conflicting ideologies and goals may hinder collaborative efforts between stakeholders from both the mental health and legal systems.

Nevertheless, there is emergent interest in the legal and ethical issues raised by the covert administration of medication.94 This research aims to advance the public mental health law research agenda by considering the state’s role in promoting and protecting, through law, mental health by relying on the example of the covert administration of medication. Understanding the legal dimensions of the practice is key to developing

92 Petrila & Swanson (2011), supra note 9 at 140 [emphasis added].
93 Welsh & Deahl, supra note 14.
94 See, for example, Tom Blackwell, “When doctors hide pills in a patient’s food, is it a breach of trust or a ‘practical way’ to ensure they take their medicine?”, National Post (26 June 2013). See also Joseph Brean, “Ruling says hospital can’t force anti-psychotic drug on patient after questionable schizophrenia diagnosis”, National Post (31 July 2013). In addition, a section of a recent issue of the Indian Journal of Psychiatry was devoted to covert medication.
oversight mechanisms, rigorous policies, professional guidelines and clinical protocols related to the covert administration of medication.

Chapter 2 (“Theoretical Frameworks”) defines the rights-based approach as capable of supporting an understanding of the rights-impact of the covert administration of medication. Additionally, critical legal accounts that assist the identification and interrogation of the complex power relationships that support or maintain its practice are explored.

Chapter 3 (“Legal and Governance Landscape”) offers an overview of Ontario’s civil mental health laws and applicable international law.

Chapter 4 (“Literature Review”) summarizes the literature surrounding the practice of covert medication, including argument-based and empirical scholarship relevant to the practice.

Chapter 5 (“Methods and Methodology”) describes this research’s critical qualitative methodological approach and its two-part research design. In the first phase, relevant policies and practice guidelines were reviewed. In the second phase, focus groups and individual interviews were conducted, relying on a discussion of three clinical case scenarios. Participants included (1) legal experts (including patient advocates and ex-patient advocates) (2) nurses with inpatient psychiatric nursing experience and (3) psychiatrists.

Chapter 6 (“Results”) summarizes the research findings. Few institutional policies, clinical protocols or practice guidelines govern the practice. The available policies were clear that the practice should only be considered for patients who are incapable of giving consent to the proposed treatment. Chapter 6 also summarizes findings of the practice’s impact on the rights-experience of adult inpatients as well as the structures that underlie its practice.
Chapter 7 ("Discussion") draws linkages between the data, the literature and the researcher’s experiences. It tells the story of the research and aims to set the stage for a conversation about the development of better practices to approaching treatment refusal in psychiatric settings. It also highlights the limitations of the study and identifies areas for further research to broaden the practice’s evidence base and set the stage for additional overt discussion about the practice.
CHAPTER 2: THEORETICAL FRAMEWORKS

This chapter examines the theoretical frameworks relevant to the examination of the practice of the covert administration of medication to incapable adult inpatients in psychiatric settings. In particular, this chapter considers how particular theoretical lenses influenced the conceptualization of the target phenomena (covert administration of medication). Continuous attention to these theoretical underpinnings informed the literature review, the development of qualitative methodological strategies (including the interview topic guide) and the data analysis.

This exploration of the practice of the covert administration of medication is premised on a rights-based approach. While the thesis offers attention to rights approach, it does so from a critical perspective. Critical Legal Studies, New Legal Realism and Critical Disability Theory assist the identification and interrogation of the complex power relationships at play in the covert administration of medication. By adopting both rights-based and critical legal lenses, this research balances a focus on the rights situation of persons in psychiatric settings and attention to how those rights are expressed.

I. RIGHTS-BASED APPROACHES

Research that relies on rights-based frameworks is action-oriented and emphasizes opportunities for change.95 Rights-based approaches are also useful for identifying and addressing underlying determinants of mental health.96 For example, rights-based

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95 Benjamin M Meier, Lance Gable, Jocelyn E Getgen & Leslie London, “Rights Based Approaches to Public Health Systems” in Elvira Beracocrea, Corey Weinstein & Dabney Evans, eds, Rights Based Approaches to Public Health (New York: Springer Publishing, 2010) 19 at 19: “With the understanding that health vulnerability is societally structured, public health systems can be seen to protect and promote the health of entire societies, employing multi-disciplinary interventions to address the underlying causes of health and disease. By employing the language of human rights in health-related issues such as equity, discrimination and social marginalization, public health advocates can achieve tangible health policy gains.”

approaches have been applied to the educational services for children, food-security and the right-to-health claims of people living with HIV/AIDS. Wronka (2008) offered other examples of rights-based research in health. Freeman (2011) commented on the role of social scientists in understanding human rights protections:

Lawyers make judgments as to whether human rights have been respected or violated. Social scientists seek to explain why human rights have been respected or violated.

Specifically, this research attends to the rights-experience of persons with mental disabilities. A rights-based approach to disability draws on the struggle for equality on the basis of race, gender, sexuality and religion. Rights-based approaches offer attention to “ways to respect, support and celebrate human diversity by creating the conditions that allow meaningful participation by a wide range of persons, including persons with disabilities.” This research defines “disability” to explicitly include mental health and/or experience with psychiatric systems.

j) Law Commission of Ontario’s Framework

The Law Commission of Ontario’s (LCO) Framework for the Law As It Affects Persons with

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Disabilities\textsuperscript{104} is a useful starting point to understand the impact of covert medication on the rights-experience of persons involved in the psychiatric system. The LCO’s Framework is based on the legal foundations of the Charter of Rights and Freedoms\textsuperscript{105}, Ontario’s Human Rights Code\textsuperscript{106}, the Accessibility for Ontarians with Disabilities Act (AODA)\textsuperscript{107} and the United Nation’s Convention on the Rights of Persons with Disabilities (CRPD)\textsuperscript{108}. The LCO identified six principles that are key to understanding how laws, policies and practices impact persons with disabilities:

1. Respecting dignity and worth of persons with disabilities\textsuperscript{109};
2. Responding to Diversity in Human Abilities and Other Characteristics\textsuperscript{110};
3. Fostering Autonomy and Independence\textsuperscript{111};
4. Promoting social inclusion and participation\textsuperscript{112};
5. Facilitating the right to live in safety\textsuperscript{113}; and
6. Recognizing that we all live in society\textsuperscript{114}.

\textsuperscript{104} LCO Framework (2012), supra note 63.
\textsuperscript{105} Constitution Act, 1982, Schedule B to the Canada Act 1982 (UK), 1982, c 11 at s 52 [Charter].
\textsuperscript{107} Accessibility for Ontarians with Disabilities Act, SO 2005, c 11.
\textsuperscript{109} LCO Framework (2012) supra note 104 at 3. “This principle recognizes the inherent, equal and inalienable worth of every individual, including every person with a disability. All members of the human family are full persons, with the right to be valued, respected and considered and to have both one’s contributions and needs recognized”
\textsuperscript{110} LCO Framework (2012) supra note 104 at 3. “This principle requires recognition of and responsiveness to the reality that all people exist along a continuum of abilities in many areas, that abilities will vary along the life course, and that each person with a disability is unique in needs, circumstances and identities, as well as to the multiple and intersecting identities of persons with disabilities that may act to increase or diminish discrimination and disadvantage.”
\textsuperscript{111} LCO Framework (2012) supra note 104 at 3. “This principle requires the creation of conditions to ensure that persons with disabilities are able to make choices that affect their lives and to do as much for themselves as possible or as they desire, with appropriate and adequate supports as required.”
\textsuperscript{112} LCO Framework (2012) supra note 104 at 3. “This principle refers to designing society in a way that promotes the ability of all persons with disabilities to be actively involved with their community by removing physical, social, attitudinal and systemic barriers to exercising the incidents of such citizenship and by facilitating their involvement.”
\textsuperscript{113} LCO Framework (2012) supra note 104 at 3. “This principle refers to the right of persons with disabilities to live without fear of abuse or exploitation and where appropriate to receive support in making decisions that could have an impact on safety.”
\textsuperscript{114} LCO Framework (2012) supra note 104 at 3. “This principle acknowledges that persons with disabilities are members of society, with entitlements and responsibilities, and that other members of society also have entitlements and responsibilities.”
The LCO considered the tensions between the principles, particularly potential conflicts between the principles of autonomy and security. The LCO also considered the *interrelationships* between the principles:

... [T]he principles cannot be neatly separated from each other, and are interrelated in multiple ways. The principles of dignity and independence, for example, cannot be achieved without respect for the principle of safety. The principle of safety has sources in the respect for the inherent worth and dignity of persons with disabilities.\(^{115}\)

Substantive equality is an “an underlying value” and an “overarching aim” of the Framework.\(^{116}\) Substantive equality guides the interpretation of the six principles.\(^{117}\) Substantive equality is distinguished from formal equality since it “rejects the mere presence or absence of difference as an answer to differential treatment.”\(^{118}\) The protections of substantive equality for persons with disabilities depend on attention to the effects of ableism, the expression of systemic values about persons with disabilities that undermine their inherent personal value and worth.\(^{119}\) Common ableist misperceptions include: persons with disabilities have a poor prospect for recovery and that persons with disabilities are presumed to be incapable of making treatment decisions. Ableist attitudes may also influence decisions about their “best interests”.

LCO also emphasized access to justice as a key principle, describing gaps between “law-in-action” and “law on the books”.

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\(^{115}\) LCO Framework (2012), *supra* note 104 at 94.

\(^{116}\) LCO Framework (2012), *supra* note 104 at 100. “Each of the six principles contributes to an overarching goal of promoting substantive equality for persons with disabilities.”

\(^{117}\) LCO Framework (2012), *supra* note 104 at 101. At 84, LCO found that the “interpretation of the principles must be informed by the concept of substantive equality.”


\(^{119}\) LCO Framework (2012), *supra* note 104 at 211. See also at 1: “Negative attitudes and stereotypes, manifested at both the individual and the systemic levels, as well as the tendency to overlook the very existence of persons with disabilities, create barriers for persons with disabilities across a broad spectrum of environments.”
Laws may be positive on paper, but may fall short of their goals in practice for several reasons, including barriers that persons with disabilities and other marginalized groups may face when attempting to obtain information about their rights and responsibilities under the law; failure to ensure that processes accommodate disability-related needs; reliance on self-advocacy to navigate complex systems; power imbalances between persons with disabilities and service providers; limited resources; and a lack of monitoring and accountability mechanisms.\textsuperscript{120}

The LCO Framework aimed to guide the development and the evaluation of law, policies and practice to “ensure the realities of the circumstances and experiences of persons with disabilities are taken into account”.\textsuperscript{121} As an example, the LCO applied its Framework to Ontario’s Community Treatment Orders (CTOs): a legal means of mandating that patients discharged from hospital pursue community treatment in order to prevent the need for further hospitalization.

One of several conditions for the issuance of a CTO is the development of a community treatment plan that is agreed to by the physician issuing the CTO, the patient or his or her substitute decision-maker, and the community agencies that will be providing services under the plan. The patient or his or her substitute decision-maker must give informed consent to the plan. In this sense, CTOs are entered into voluntarily. However, the reality is that consent to a CTO is often a condition to being released from hospital and this is a powerful incentive for many patients to consent. Further, failure to comply with a CTO may result in apprehension by the police and involuntary readmission to the hospital. These requirements are intended to facilitate living in safety and the ultimate goal of social inclusion and participation, but they mean that although strictly speaking the CTO regime is voluntary, it may be considered to contain a significant degree of coercion.\textsuperscript{122}

The research is unique for its reliance on the LCO’s recently developed Framework. The LCO developed a related framework to evaluate laws, policies and practices in order to

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\item \textsuperscript{120} LCO Framework (2012), supra note 104 at 1.
\item \textsuperscript{121} LCO Framework (2012), supra note 104 at 112.
\item \textsuperscript{122} LCO Framework (2012), supra note 104 at 15.
\end{itemize}
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understand their impact on older adults.\textsuperscript{123} The LCO’s two frameworks - one about the law as it applies to persons with disabilities and the other about the law as it applies to older adults - have provided the foundation for a new project on legal capacity, decision-making and guardianship in Ontario.\textsuperscript{124}

\textbf{ii) Broad Conceptualizations of “Rights”}

As set out in Chapter 1 (“Introduction”), the fields of human rights and public health are complementary. To Gostin and Powers (2006), a robust conception of justice is central to the mission of public health.\textsuperscript{125} Nixon and Foreman (2008) highlighted the “conceptual synergy” of an approach that combines the frameworks of human rights and public health. Mann (1997) characterized public health and human rights as “allies”.\textsuperscript{126} Human rights values illustrate the principles underlying public health approaches.

Rights and health - including mental health - are intertwined, interdependent and “inextricably linked.”\textsuperscript{127} Gostin (2001) described the reciprocal relationship between mental health and human rights.\textsuperscript{128} First, mental health is necessary for the expression of human rights since “only those who possess some reasonable level of functioning can engage in political and social life”.\textsuperscript{129} That is, a minimum level of mental health is necessary to ensure the enjoyment of other human rights.\textsuperscript{130} Conversely, human rights are necessary for mental health since human rights offer protection and security from

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\item \textsuperscript{123} Law Commission of Ontario, \textit{A Framework for the Law as It Affects Older Adults} (Toronto: LCO, 2012).
\item \textsuperscript{125} Gostin & Powers (2006), \textit{supra} note 65.
\item \textsuperscript{126} Mann (1997), \textit{supra} note 32 at 9: “Modern human rights, precisely because they were initially developed entirely outside the health domain and seeks to articulate the societal preconditions for human well-being, seem a far more useful framework, vocabulary and form of guidance for public health efforts to analyze and respond directly to the societal determinants of health than any inherited from the past biomedical or public health tradition.”
\item \textsuperscript{127} Human Rights Watch, \textit{Health and Human Rights} (2013), online: HRW <www.hrw.org/sites/default/files/related_material/2013_Brochure_HHR.pdf>.
\item \textsuperscript{128} Gostin (2001), \textit{supra} note 137 at 266: “...mental health and human rights are inextricably linked.”
\item \textsuperscript{129} Gostin (2001), \textit{supra} note 137 at 266.
\item \textsuperscript{130} Gable & Gostin (2009), \textit{supra} note 11 at 250.
\end{itemize}
harm and support wellbeing.\textsuperscript{131} Indeed, mental health is an imperative of human rights.\textsuperscript{132}

A rights-based approach offers a framework for identifying and responding to underlying social determinants of health.\textsuperscript{133} The UN Committee on Economic, Social and Cultural Rights’ (CESCR) \textit{General Comment 14} recognizes that the right to health includes underlying determinants of health.\textsuperscript{134} Meier and others (2010) proposed that the application of human rights standards “as a substantive and decision-making framework, human rights can be applied to create a rights-based approach to underlying determinants of health.”\textsuperscript{135} Emergent scholarship understands access to justice as a social determinant of health.\textsuperscript{136} As expanded upon in Chapter 7 (“Discussion” in “Procedural Rights and Accessibility of Review Processes”), covert medication raises questions about the access to procedural protections, including where neither the patient nor the SDM have information to challenge the decision to covertly medicate. If both patient and the SDM are unaware of the fact of the covert administration of

\begin{itemize}
\item \textsuperscript{131} Gostin (2001), \textit{supra} note 137 at 266: “Some measure of mental health is indispensable for human rights because only those who possess some reasonable level of functioning can engage in political and social life [citation]. Similarly, human rights are indispensable for mental health because they provide security from harm or restraint and the freedom to form, and express, beliefs that are essential to mental well-being.”
\item \textsuperscript{132} Gable \& Gostin, (2004), \textit{supra} note 52.
\item \textsuperscript{133} Mann (1997), \textit{supra} 32 at 10: “A third relationship between health and human rights has already been suggested; namely, that promoting and protecting human rights is inextricably linked with promoting and protecting health. Once again, this is because human rights offer a societal-level framework for identifying and responding to the underlying-societal-determinants of health. It is important to emphasize that human rights are respected not only for their instrumental value in contributing to public health goals, but for themselves, as societal goods of pre-eminent importance.”
\item \textsuperscript{134} \textit{General Comment 14: The Right to the Highest Attainable Standard of Health (Article 12)}, CESR, 22nd Sess, UN Doc E/C.12/2000/4 (11 August 2000).
\item \textsuperscript{135} Meier \textit{et al} (2010), \textit{supra} note 95 at 28. See also at 25: “Bringing the lens of discrete legal obligations to these determinants of health will help to sharpen state accountability in ways that have not yet emerged.”
\item \textsuperscript{136} Robin Nobleman, “Addressing Access to Justice as a Social Determinant of Health” (2014) 21 Health LJ 49; Access to Justice and the Health of Canadians, “Does Your Health Depend on Your Access to Justice?” (Paper delivered to the Health Promotion Ontario in Toronto ON, 27 September 2012), online: Access to Justice and the Health of Canadians \textless www.justiceandhealth.ca\textgreater; Robin Nobleman, “Are Health Problems Legal Problems in Disguise? Access to Justice as a Social Determinant of Health” (13 July 2013) Canadian Forum on Civil Justice, online: CFCJ \textless www.cfcj-fcjc.org/a2\textgreater blog/are-health-problems-legal-problems-in-disguise#sthash.UwLuBEwb.dpuf: “Many of these problems [poor housing, insecure employment, inadequate education] may actually be unmet legal needs that can be dealt with in a poverty law practice. In other words, legal services have the power to impact social determinants of health, and I propose that access to these services can be a social determinant of health in itself.”
\end{itemize}
medication, neither is able to challenge the decision to administer medication covertly. There are other practical barriers to the litigation of claims related to covert medication, including the affordability and accessibility of legally-aided services.

This research relies on a broad understanding of the “impact on rights experience” as set out by the second research question. The practice’s clinical impacts may have an indirect effect on the patient’s rights-situation. Rights-protection is fundamental to the promotion of mental health. Health and well-being are also keys to the exercise of other rights. That is, a patient who remains unwell may experience barriers to asserting her rights.

iii) Challenges to Rights-Based Approaches

Rights approaches have been criticized for adopting a binary, formulaic approach to understanding rights – that is, either a practice breaches a right or it does not. Rights approaches have also been criticized for being unable to make sense of why some rights are protected and why others are not, thus, avoiding consideration of the larger political and social meanings of “rights”. Questions have been raised as to whether human

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138 WHO (2004), supra note 96 at 23: “A climate that respects and protects basic civil, political, economic, social, and cultural rights is fundamental to the promotion of mental health. Without the security and freedom provided by these rights, it is very difficult to maintain a high level of mental health.”
139 Duncan Kennedy, “The Critique of Rights in Critical Legal Studies” in Wendy Brown & Janet Halley, eds, Left Legalism/Left Critique (Durham NC: Duke University Press, 2002). See also John Henry Schlegel, “Critical Legal Studies” in Sally E Hadden & Alfred L Brophy, eds, A Companion to American Legal History (Hoboken: Wiley, 2013) at 524: “The first proposition, known as the indeterminacy thesis, asserted that since law was structured as a system of binary oppositions it allowed two opposed conclusions in any significantly litigated case. The second, known as the critique of rights, asserted that because of the indeterminacy at the heart of law, rights could and would be manipulated in the interest of the dominant forces in a given society and so provided limited protection from the actions of others or the state for individuals and groups outside those dominant forces.” See also Lorne Foster & Lesley Jacobs, “Shared Citizenship as the Context for Competing Human Rights Claims: Towards a Social Policy Framework” (2010) 8:3 Canadian Diversity 10 at 11: “They have a paradoxical nature in that they allow us to challenge inequalities whilst contributing to the production of social divisions.”
140 Diana Majury, “The Charter, Equality Rights and Women: Equivocation and Celebration” (2002) 40: 3–5 Osgoode Hall L J 298 at 301: “By abstracting and individualizing, rights and rights discourse are seen to depoliticize issues of power and domination, making them more palatable and manageable, even
rights obligations are “universal” or whether these obligations must be adapted to the local cultural context, including in psychiatric contexts. Indeed, ethical and legal principles reflect the cultural frame in which they are created. In the specific case of covert medication, Latha (2010) challenged the “great reverence afforded to individual autonomy and independence in developed societies.” Hanlon and colleagues (2010) argue that Western-based ideological emphasis on “autonomy” does not generalize to low and middle-income countries where families are primary care givers and where familial inter-dependence is emphasized. In these cases, the autonomous unit, and not the family, is the patient.

There are associated questions about the effectiveness of litigation strategies to remedy failures to protect “rights”. For instance, some are skeptical about the role of Canada’s Charter of Rights and Freedoms, pointing to concerns about its effectiveness, accessibility and unintended consequences. Others challenge that the Charter’s individualistic protections are not amenable to group-based rights analysis. Majury (2002) reflected on these challenges to Charter rights as “cautions” rather than reasons to reject rights perspectives entirely. Identifying herself as a Charter-pragmatist, Majury described the Charter as a forum for raising ideas and as “one among a limited number of potential tools to expose and to argue for the redress of women’s and other marginalized groups’ subordination.”

rendering them invisible.”

145 Majury (2002), supra note 140.
146 Majury (2002), supra note 140 at 303.
II. CRITICAL THEORIES OF RIGHTS

While this research adopts a rights-based approach, it also relies on critical understandings of those rights. It goes beyond an enumeration of different interpretations of covert medication. Rather, this research applies critical frameworks to explore how the law is lived, in an everyday sense, by persons involved in the psychiatric system. This departs from a traditional starting point of “what is the law?”

This research adopts multiple and complementary critical theories of rights: Critical Legal Studies, New Legal Realism and Critical Disability Studies. Their combined attention permits a fulsome exploration of the practice, including the practice’s structural and ideological influences. These critical accounts get at the contexts and underpinnings of medication administration practice.

This research considers the influence of institutional power - including the power to be silent. These critical accounts facilitate the examination of covert administration as an example of the law's reproduction of the power structures inherent in psychiatric systems. As a “product of the societies they purport to govern”, the law privileges the claims of the powerful against the powerless. These three critical accounts consider how the law works to reinforce and reproduce power structures.

149 Reeves et al (2008), supra note Error! Bookmark not defined. at 633: “Critical theorists study how the construction of knowledge and the organization of power in society generally, and in institutions such as schools, hospitals, and governments specifically, can lead to the subjugation or oppression of particular individuals, groups, or perspectives.”
150 David L Hosking, “Critical Disability Theory” (Paper delivered at the Disability Studies Conference,
i) Critical Legal Studies

Critical Legal Studies (CLS) first emerged in the 1970s. Critical legal theorists, relying on the work of post-structuralists characterize law and society as mutually constitutive. Rather than an “external apparatus”, legality is socially experienced and has effect beyond what is formally embodied by texts, statutes or constitutions. Law serves to protect the interests of the privileged against the claims of persons from vulnerable communities, including persons with mental health issues. For instance, Perlin (1999) emphasized the influence of “sanism” and “pretextuality” on mental disability law and jurisprudence. Other structural functionalist approaches, including the work of Waitzkin (2000), take into account the power structures reflected in and replicated by the psychiatric system.

Critical understandings of the law highlight the regulation of capacity, distinguished from dominant understandings of capacity as an objective attribute. Fineman (2008) theorized a concept of vulnerability that embraces a more substantive vision of equality. Satz (2008) applied Fineman’s theory of vulnerability to critical disability studies. CDS may also challenge traditional understanding of autonomy as requiring

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153 Michael L Perlin, “Half-wracked Prejudice Leaped Forth: Sanism, Pretextuality, and Why and How Mental Disability Law Developed as it Did” (1999) 10 J Contemp Legal Issues 23. See also Michael L Perlin, “Sanism and the Law” (2013) 15:10 Am Med Ass J Ethics 878 at 878: “Sanism’, an irrational prejudice against people with mental illness, is of the same quality and character as other irrational prejudices such as racism, sexism, homophobia, and ethnic bigotry that cause (and are reflected in) prevailing social attitudes. It infects both our jurisprudence and our lawyering practices. Sanism is largely invisible and largely socially acceptable. It is based predominantly upon stereotype, myth, superstition, and deindividualization and is sustained and perpetuated by our use of alleged “ordinary common sense” (OCS) and heuristic reasoning in irrational responses to events in both everyday life and the legal process.”
154 Martha A Fineman, “The Vulnerable Subject: Anchoring Equality in the Human Condition” (2008) 20:1 Yale J L & Feminism 1 at 12: “The vulnerability approach recognizes that individuals are anchored at each end of their lives by dependency and the absence of capacity. [...] On an individual level, the concept of vulnerability (unlike that of liberal autonomy) captures this present potential for each of us to become dependent based upon our persistent susceptibility to misfortune and catastrophe.”
self-sufficiency. Sherwin (1998) offered a feminist reconceptualization of the notion of autonomy, which offers particular attention to the “political dimensions of the multiple relationships that structure an individual’s selfhood”\(^\text{156}\) and the “social and political dimension in which [autonomy] resides.”\(^\text{157}\) Wildeman (2012) drew on the Supreme Court’s decision in *Starson v Swayze* to advance Sherwin’s relational autonomy approach.\(^\text{158}\) She proposed that the “…attainment of the requisite reflective abilities is not, and cannot be, a solo endeavor but rather, requires social supports.”\(^\text{159}\) Chapter 4 (“Literature Review”) further considers recent scholarship about supported decision-making models.

This research relies on an understanding of how the psychiatric system operates with the legal system to manage “risky” treatment-resistant patients. Beckett and Murakawa (2012) described the “shadow carceral state” which expands the law’s reach beyond criminal law and justice systems.\(^\text{160}\) Rose (2010) also described how “risky” treatment-resistant patients are governed under the radar, without full resort to the operation of the law.\(^\text{161}\) Rose describes this as “governance through neurochemistry.”\(^\text{162}\) Kilty (2008) disability legal studies, I argue that vulnerability to disability and the vulnerabilities disabled individuals experience more acutely than those without disability are both universal and constant.”


\(^\text{157}\) Sherwin (1998), *supra* note 156 at 44: “A relational approach to autonomy allows us to maintain a central place for autonomy within bioethics, but it requires an interpretation that is both deeper and more complicated than the traditional conception acknowledges – one that sets standards that involve political as well as personal criteria of adequacy.”


\(^\text{159}\) Wildeman (2012), *supra* note 157 at 269.

\(^\text{160}\) Katherine Beckett & Naomi Murakawa, “Mapping the Shadow Carceral State: Toward an Institutionally Capacious Approach to Punishment” (“2012” 16 Theoretical Criminology 221 at 222: “In institutional terms, the shadow carceral state includes institutional annexation of sites and actors beyond what is legally recognized as part of the criminal justice system: immigration and family courts, civil detention facilities, and even county clerks’ offices. Although these institutions are not officially recognized as ‘penal’, they have nonetheless acquired the capacity to impose punitive sanctions— including detention—even in the absence of criminal conviction. The shadow carceral state also operates in opaque, entangling ways, ensnaring an ever-larger share of the population through civil injunctions, legal financial obligations, and violations of administrative law.”

\(^\text{161}\) Nikolas Rose, “Screen and Intervene: Governing Risky Brains” (2010) 23:1 Hist Hum Sci 79 at 88: “I call this ‘governing through madness’. By this I mean the ways in which contemporary politics of mental health
described the use of prescription medications to sedate female prisoners in correctional settings. Like Rose (2010), she described this as governance through responsibilization:

Correctional authorities thus reconstruct prisoners as failing to self-responsibilise, as attention seeking, and as manipulative ‘bad women’ in order to justify their carceral control.... Prisoners are now responsible for their own reformation thereby eliminating the responsibility of psy and correctional experts to rehabilitate them. If a woman recidivates it is because she failed to embrace correctional discourse and knowledge, which is saturated with psy explanations of behaviour.  

Critical legal studies will guide this exploration of how covert medication expresses, reflects and maintains relationships of power in Ontario’s psychiatric settings.

ii) New Legal Realism

As a theory of law, legal realism is concerned with the actual workings of the legal system. This research rests on the principle that the covert administration of medication is an example of how the law (including “rights”) is lived, in an everyday sense, by persons involved in psychiatry systems. To New Legal Realists (NLR), however, the law does not have clear or specific effect. \(^{164}\) NLR scholarship is concerned with the everyday

\(^{162}\) Rose (2010), supra note 161 at 88. “... Historical precedents would suggest that such strategies are unlikely to reduce the overall frequency of the very rare incidents they seek to prevent. But they are likely to result in threshold-lowering and net-widening, and the detention of many individuals who are capable of leading lives that might sometimes be troublingly different but would pose no dangers to others.”

\(^{163}\) Jennifer M Kilty, “Governance through Psychiatrization: Seroquel and the New Prison Order” (2008) 2:7 Radical Psychology 2: “While steeped in a medical tradition that seeks to find a biological explanation for human behaviours and mental illness, in order to maintain power with respect to carceral governance, psy experts must now address behaviour as a choice. However, the correctional use of prescription medications to effectively sedate rowdy or misbehaving prisoners, actually mollifies that choice. Subsequently, the problematic behaviour remains an individual issue within each woman, and experts are able to use her (mis)behaviour to reinforce the hierarchy of psy within the prison.”

(in)determinacy of the law.\textsuperscript{165} It is characterized by reliance on a variety of social science methods including qualitative methods,\textsuperscript{166} and a "bottom up" approach to understanding the everyday experience of law.\textsuperscript{167}

NLR facilitates the examination of the application of the law at the outer-edges of psychiatric practice. It may be that the law has trouble understanding complex areas where there are conflicting interests and, as such, defaults to the more powerful interests, reproducing inequality. Silbey (2005) considered how the "law sustains its institutional power despite a persistent gap between law on the books and law in action."\textsuperscript{168}

iii) Critical Disability Studies

Critical Disability Studies (CDS) emphasize questions about how the law and legal institutions impact persons with disabilities, including those involved with psychiatric institutions.\textsuperscript{169} In the 1980s and 1990s, feminist legal scholars and critical race theorists

\textsuperscript{165}Arthur F McEvoy, “A New Realism for Legal Studies” (2005) Wisc L Rev 433 at 434-435: “New realist scholarship is distinctive for its emphasis on the reciprocal interaction between law, environment, and culture. [...] Environment is the realm from which challenges emerge that lead people to invoke the law. Culture [...] includes both the meanings that people carry in their heads and the meanings that they manifest in their behavior.”

\textsuperscript{166} Thomas Mitchell & Elizabeth Mertz, “The Empirical Turn in the Legal Academy: A New Legal Realist Perspective” (November 2006) Law & Society Newsletter 4-5: “Apart from a greater focus on translation and opportunities for using multiple methods, the NLR project also recognizes that many legal and social phenomena simply have not been studied at all using quantitative methods because to do so would be impractical or indeed impossible. A complementary “bottom-up” or contextual approach can open the field of empirical inquiry to a much broader range of socio-legal phenomena. Moreover, grounded qualitative studies can generate “middle range” theory that in turn can seed the ground for further, better informed quantitative studies.”

\textsuperscript{167} Mark Suchman & Elizabeth Mertz, “Toward a New Legal Empiricism: Empirical Legal Studies and New Legal Realism” (2010) 6:1 Ann Rev L & Soc Sci 555 at 564: “Although no one has gone so far as to disavow the legal relevance of examining extralegal disputing processes or everyday legal consciousness, ELS [Empirical Legal Studies] tends to highlight the top-down legal institutions of the state, whereas NLR [New Legal Realism] tends to highlight the bottom-up normative contexts of civil society.”

\textsuperscript{168} Susan S Silbey, “After Legal Consciousness” (2005) 1 Ann Rev Doc Sci 323 at 323: “Why do people acquiesce to a legal system that, despite its promises of equal treatment, systematically reproduces inequality?”

identified the limitations of CLS, arguing that it was unable to respond to the interests of oppressed minorities. Critical Race Theory evolved, at least in part, from the failure of CLS to adequately account for the role of race in legal institutions.170

The research relies on a critical disability approach to direct the examination of the impact of covert administration to the rights-situation of persons with mental health issues. CDS is relied upon to identify and interrogate the complex power relationships at play in the covert administration of medication. CDS identifies the overt and covert barriers within “formal law” and legal institutions.171 CDS's emphasis on underlying structures begs the question, “If the covert administration of medication is happening, what else is happening?”

CDS also offers a framework to problematize concepts of autonomy, personal independence and interdependence: concepts often invoked in the debates surrounding covert medication.172 The social model of disability proposes that factors external to a person's actual limitations determine that person's ability to function within society. The social model of disability is sensitive to the phenomenon of “social handicapping” and that a person may have no functional limitations other than those created by labeling, prejudice, stigma and stereotype.173 It recognizes that social attitudes alone can construct “disability”, including mental illness.174 Notably, the Supreme Court of Canada
adopted the social model of disability in Quebec v Boisbriand (City).175

Critics of the social model of disability argue that it fails to integrate an appreciation of actual impairment.176 Minnow (1990) articulated the ‘dilemma of difference’, challenging the social model of disability for its shift of focus from impairment and its aim to make disability “invisible”.177 The World Health Organization recently adopted a hybrid ‘bio-psycho-social model’ of disability that acknowledges disablement as “a dynamic interaction between health conditions and contextual factors, both personal and environmental.”178

Unlike other CLS movements, CDS characterizes the law as a tool to advance the emancipatory claims of persons with disabilities.179 CDS identifies the potential positive role of law and seeks to create and use existing law and enlist legal institutions in the struggle for the emancipation of persons with disabilities.180 From this pragmatic perspective, the law may be a tool to advance the interests of persons with mental health issues. On the other hand, Chouinard (2001) echoed CLS’s emphasis on the gap between “law-on-the-books” and “law-in-practice” by considering the political and economic barriers to the exercise of legal protections owed to persons with disabilities:

Disabled peoples’ economic places in society and space greatly limit their capacities to assert rights won under Canadian law. [...] These are places of ‘shadow citizenship’ in which rights enjoyed in principle are difficult or impossible to exercise in practice.181

179 Hosking, supra note 150.
180 Rioux & Valentine (2006), supra note 102 at 69: “Achieving equality for persons with disabilities, however, requires that all political, administrative and judicial actors understand the meaning and experience of disablement as nothing short of full citizenship status. Getting to this point, however, will require significant and ongoing debate in our legislatures, our courtrooms, and in civil society.”
181 Vera Chouinard, “Legal Peripheries: Struggles over disabled Canadians’ places in Law, Society and Space” (2001) 45 Canadian Geographer 187 at 189. She continued at 191: “Disabled Canadians have fought
CDS also offers comment on the methodological questions that arise in the act of researching disablement, including in persons involved in psychiatric settings. Oliver (1992) attacked disability research as having done little to confront the oppression and isolation of persons with disabilities.\[^{182}\] Barnes and Mercer (1997) argued that disability research must challenge the conceptualization of disability as an individual pathology, a medical problem or a personal tragedy to be pitied.\[^{183}\] CDS researchers have relied on critical social research to establish “openly partisan and politically committed research”.\[^{184}\] Stone & Priestly (1996) argued that the focus of disability research should be less about the ability of persons to cope with their disability and more about the identification and removal of barriers.\[^{185}\]

III. Synergistic Combinations of Rights-Based and Critical Approaches

This research engages both a rights-based approach as well as critical accounts of such rights. At first glance, these two approaches appear incompatible. However, despite their differences in focus, the two perspectives (rights-based and critical rights theories) complement each other in that the gaps left by one framework are addressed by the

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184 Barnes & Mercer (1997), supra note 183 at 3: “Although not a unitary body of thought, ‘critical social research’ has achieved a pre-eminent influence on disability researchers, at least in its emphasis on emancipatory goals, and its calls for openly partisan and politically committed research.”
185 Emma Stone & Mark Priestley, “Parasites, Pawns and Partners: Disability Research and the Role of Non-Disabled Researchers” (1996) 47:4 Br J Sociol 699 at 702: “In particular, where disability is defined in social and material terms, the focus of disability research will have less to do with the ability of disabled people to ‘cope with’ or ‘adapt to’ their situation and more to do with the identification and removal of disabling physical and social barriers.”
other. This study balances (i) a focus on the “rights” of persons in psychiatric settings and (ii) attention to how “rights” are expressed, with an eye towards change. A rights-based analysis is applied in order to consider how stakeholders understood the impact of covert medication on the rights-experience of adult inpatients in psychiatric settings in Ontario. By also concentrating on covert medication’s structural and ideological influences, this research aims to get at the contexts and underpinnings of covert medication administration practice.

This research adopts multiple and complementary critical theories of rights. Instead of contemplating the practice’s compatibility with the Charter or the CRPD, critical approaches guide an exploration of the social and political meanings of the practice’s constitutionality or legality. A careful examination of the expression, nature and value of rights is especially pressing since the practice engages conflicting rights. Chapter 7 (“Discussion”) expands on the conflicting rights engaged by the practice of the covert administration. While adult inpatients in psychiatric settings must enjoy a right to make decisions about their own bodies, they must also enjoy the right to receive treatment when they are not capable of consenting to it on their own.
CHAPTER 3: LEGAL AND GOVERNANCE LANDSCAPE

This chapter reviews the legal and governance landscape relevant to the covert administration of medication to adult inpatients in psychiatric settings in Ontario. The “covert administration of medication” is defined here as concealment of medication in food or drink so that it will be consumed undetected. A variety of agencies and governing bodies were contacted including all provincial and territorial Colleges of Physicians and Surgeons, all provincial and territorial regulatory colleges of nurses, all provincial and territorial medical and nursing associations and a variety of specialist associations, including the Psychiatric Patient Advocacy Office (PPAO), Canadian Medical Protective Association (CMPA) and the Canadian Nurses Protective Association (CNPS). The Hansard records of debates were searched, including the debates in Ontario’s Legislature during the first, second and third readings of the amendments to the Substitute Decisions Act, Health Care Consent Act and the Mental Health Act (1991-1992).

I. ONTARIO LEGISLATION

This section reviews Ontario legislation and regulations specific to treatment and consent issues that are relevant to inpatients of psychiatric settings in Ontario, including community hospitals, facilities designated as Schedule I to Ontario’s Mental Health Act, non-Schedule 1 facilities, forensic settings and what were once known as Provincial Psychiatric Hospitals (PPH). Since there are no statutory materials specific to the

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186 This exploration complemented, but was distinct from the document review, as described in Chapter 5 (“Methods and Methodology”).

187 Schedule 1 facilities are required to provide psychiatric services including on an inpatient basis. See Mental Health Act, RRO 1990, O Reg 741 at s 4(1): “Unless exempted therefrom by the Minister under subsection 80.2 (1) of the Act, every psychiatric facility shall offer a program that includes the following essential services: 1. In-patient services. 2. Out-patient services. 3. Day care services. 4. Emergency services. 5. Consultative and educational services to local agencies” and at s 4(3): “The list of psychiatric facilities designated by the Minister, their classifications, as well as any exemption from the requirement to provide the essential services mentioned in subsection (1), is available on the Internet through the website of the Ministry of Health and Long-Term Care.”

188 PPHs were also known as tertiary or specialized hospitals. Ontario Hospitals Association, Practical Guide to Mental Health and the Law in Ontario (Toronto: OHA, 2012) at footnote 111: “Formerly in Ontario, several provincially-run psychiatric hospitals were governed according to the provisions of the Mental
covert administration of medication, the legislative material reviewed here has broad application.

The legislative research focuses on the practice in Ontario. The laws that govern consent to treatment vary between provinces and territories as the administration and delivery of health care services is the responsibility of each province or territory.\textsuperscript{189} It is particularly useful to focus on Ontario given that Ontario has been considered as a forerunner in the area of consent to treatment.\textsuperscript{190} In Quebec, an order from the Superior Court is required to forcibly treat an incapable person who refuses to undergo care when a person authorized to give substituted consent gives consent.\textsuperscript{191} The health institution must go to the Superior Court to obtain an order to provide the treatment. In British Columbia, an involuntarily detained person is presumed to have given “deemed consent”
to treatment. Given the differences in mental health legislation across various jurisdictions, this chapter considers the practice’s legislative context in Ontario.

i) Health Care Consent Act, 1996

In 1996, the Health Care Consent Act (HCCA) replaced the Consent to Treatment Act when the Advocacy, Consent and Substitute Decisions Statute Law Amendment Act was brought into force. At that time, the Advocacy Act, which provided for institutional advocacy support services, was also repealed. The LCO points out that SDA and the Consent to Treatment Act “were developed in the context of the Advocacy Act, which created an ambitious institutional framework for advocacy for vulnerable individuals but which was repealed late in the development of the legislative framework.”

Section 10 of the HCCA expressly sets out that there may be no treatment without informed consent. Indeed, it is a central principle of the HCCA that there may be no treatment without informed consent from a capable person. This recognition flows from the protection of a person’s interest in bodily security from unwanted physical interference.

A person may be determined to be incapable of making a personal care decision if she is unable to understand the information relevant to making the decision or if she is unable to appreciate the consequences of a decision or lack of decision. The HCCA presumes a

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194 Health Care Consent Act, RSO 1996, c 2 at s 10 (1): “A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless, (a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or (b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person’s substitute decision-maker has given consent on the person’s behalf in accordance with this Act.”
195 HCCA, supra note 194 at s 4(1): “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
person is capable to decide to accept or reject treatment. A person may be incapable of making some treatment decisions, but not others. One’s capacity may also fluctuate with time. That is, a person may be capable of making a treatment at one time, but not at another.

If an HCP determines that a person is not capable to consent to treatment, the person will be given information about the consequences of the findings of that decision. For instance, the College of Physicians and Surgeons of Ontario (CPSO) requires a physician to provide information about the person’s ability to challenge the finding of incapacity. The College of Nurses of Ontario’s Practice Guideline: Consent also includes a requirement that nurses advise patients about their rights, including their right to appeal a finding of incapacity.

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196 HCCA, supra note 194 at s 4(2): “A person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services.”

197 HCCA, supra note 194 at s 15(1): “A person may be incapable with respect to some treatments and capable with respect to others.”

198 HCCA, supra note 194 at s 15(2): A person may be incapable with respect to a treatment at one time and capable at another.”

199 HCCA, supra note 194 at s 17: “A health practitioner shall, in the circumstances and manner specified in guidelines established by the governing body of the health practitioner’s profession, provide to persons found by the health practitioner to be incapable with respect to treatment such information about the consequences of the findings as is specified in the guidelines.”

200 College of Physicians and Surgeons of Ontario (CPSO), CPSO Policy Statement on Consent to Medical Treatment (#4-05) (Toronto: CPSO, 2006), online: CPSO <www.cps.on.ca/uploadedFiles/policies/policies/policyitems/Consent.pdf > at 6-7. “The Policy requires physicians to: a) inform the incapable patient that a substitute decision-maker will assist the patient in understanding the proposed treatment and will be responsible for making the final decision; b) involve the incapable patient, to the extent possible, in discussions with the substitute decision-maker; c) if the patient disagrees with the need for a substitute decision-maker, or disagrees with the involvement of the present substitute, advise the patient of his or her options, including finding another substitute of the same or more senior rank, and/or applying to the CCB for a review of the finding of incapacity; d) reasonably assist the patient if he or she expresses a wish to exercise the options outlined above.”

201 College of Nurses of Ontario, Practice Guideline: Consent (Toronto: CNO, 2009), online: CNO <www.cno.org/Global/docs/policy/41020_consent.pdf>: “If there is an indication that the client is uncomfortable with this information, then the nurse explores and clarifies the nature of the client’s discomfort. If it relates to the finding of incapacity, or to the choice of substitute decision-maker, then the nurse informs the client of his/her options to apply to the CCB for a review of the finding of incapacity, and/or for the appointment of a representative of the client’s choice.”
If an HCP is of the opinion that a person is not capable of making a treatment decision, consent must be obtained from an SDM.\textsuperscript{202} The HCCA provides a hierarchy of substitute decision-makers.\textsuperscript{203} An SDM may be a family member or the Office of the Public Guardian and Trustee may also be appointed to this role.

Section 21 sets out the principles for an SDM in giving or refusing consent. For example, section 21(1) of the HCCA assures the primacy of prior capable wishes.\textsuperscript{204} If the SDM does not know of any such wish, or if it is impossible to comply with the wish, the SDM is required to act in the incapable person’s best interests. The determination of those best interests must include consideration of the person’s values and beliefs held when capable, any wishes expressed by the incapable person about the treatment, and whether a less restrictive or less intrusive treatment would be as beneficial as the proposed treatment.\textsuperscript{205} Where an HCP is of the opinion that an SDM has failed to comply with these principles of substitute decision-making, the HCP may apply to the Consent and Capacity Board (CCB).\textsuperscript{206} The CCB may substitute its opinion for that of the SDM and provide directions to the SDM.

There are exceptions to the general requirement for consent in the case of an emergency.\textsuperscript{207} Section 7 of the HCCA reinforces the common law duty of an HCP to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others.\textsuperscript{208}

\textsuperscript{202} HCCA, \textit{supra} note 194 at s 10(1).
\textsuperscript{203} HCCA, \textit{supra} note 194 at s 20(1).
\textsuperscript{204} HCCA, \textit{supra} note 194 at ss 35 and 36. Section 35 offers a mechanism for SDMs or HCPs to determine the applicability of prior capable wishes. Section 36 offers a mechanism for an SDM or an HCP to apply to depart from capable wishes.
\textsuperscript{205} HCCA, \textit{supra} note 194 at s 21: “Principles for giving or refusing consent”.
\textsuperscript{206} Only an HCP can apply to the CCB. Family members are not entitled to make Form G applications. HCCA, \textit{supra} note 194 at s 37.
\textsuperscript{207} HCCA, \textit{supra} note 194 at s 25.
\textsuperscript{208} HCCA, \textit{supra} note 194 at s 7: “This Act does not affect the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others.”
Section 2 of the HCCA defines “treatment” as anything done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose. It includes a course of treatment or plan of treatment. Treatment does not include “a treatment that in the circumstances poses little or no risk of harm to the person.” Ontario’s Superior Court in *SMT v Abouelnasr* (2008) found that the use of physical restraints to deliver medication is a “treatment” for a “health related purpose”. Since the application of physical restraints was a necessary incident of the treatment, Mr. SMT's SDM had impliedly consented to the use of restraints when she consented to the medication.

**ii) Substitute Decisions Act, 1992**

The *Substitute Decisions Act* (SDA) was passed by the Ontario Legislature in December 1992 and entered into force on April 3, 1995. The SDA governs the capacity of persons to make decisions about their finances as well as decisions about personal care. The SDA – like the *Health Care Consent Act* - presumes of capacity to manage property and manage personal care.\(^{209}\) The SDA defines “incapacity” to manage property and personal care, respectively:

6. A person is incapable of managing property if the person is not able to understand information that is relevant to making a decision in the management of his or her property, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.\(^{210}\)

45. A person is incapable of personal care if the person is not able to understand information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.\(^{211}\)

There are no express provisions in the SDA, or its regulations, that address the covert

\(^{209}\) SDA, *supra* note 209 at s 6.

\(^{210}\) SDA, *supra* note 209 at s 45.

\(^{211}\) SDA, *supra* note 209 at s 45.
administration of medication.

iii) Mental Health Act, 1990

Ontario’s Mental Health Act (MHA) regulates the involuntary admission of people to a psychiatric hospital.\textsuperscript{212} The MHA also governs the provision of rights advice to patients who have been involuntarily admitted to hospital. Bill 68 (referred to as Brian’s Law) amended the Mental Health Act in 2000 to include provisions about Community Treatment Orders (CTOs). CTOs are initiated by a physician and require that a person receive treatment, care or supervision in the community. A community treatment plan must be consented to and outlines the medications and appointments believed necessary to allow the person to live in the community.\textsuperscript{213} Ontario’s Mental Health Act defines the purpose of a CTO as “provid[ing] ... a comprehensive plan of community-based treatment or care and supervision that is less restrictive than being detained in a psychiatric facility.”\textsuperscript{214}

There are no specific provisions in the MHA, or its regulations, that are relevant to the covert administration of medication. Remarkably, section 49 of the MHA provides that an HCP cannot administer psychosurgery to a patient who is considered incompetent to consent to treatment. Examples of psychosurgery include electroconvulsive therapy, gamma knife irradiation and deep brain stimulation.

\textsuperscript{212} Mental Health Act, RSO 1990, cM7 [MHA].
\textsuperscript{213} Psychiatric Patient Advocacy Office (PPAO), InfoGuide: Community Treatment Orders (August 2010), online: PPAO <www.sse.gov.on.ca/mohltc/ppao/en/Pages/InfoGuides/TreatmentIssues_C.aspx?openMenu=smenu_Treatment>: “A Community Treatment Order ("CTO") is a doctor’s order for a person to receive treatment or care and supervision in the community. The treatment or care and supervision is based on a community treatment plan which outlines the medications, medical appointments and other aspects of care the doctor believes is necessary to allow the person to live in the community rather than remain in the hospital.”
\textsuperscript{214} MHA, supra note 212 at s 33.1(3).
iv) *Long-Term Care Homes Act, 2007*

As set out in Chapter 1 (“Introduction” at “Statement of Focus and Exclusion”), this research excludes consideration of the covert administration of medication in Ontario’s long-term care settings. However, a review of the legal principles that govern its practice in long-term care supports an exploration of the analogous socio-political-legal structures that underlie the practice in Ontario’s psychiatric settings.\(^\text{215}\)

Taking effect in 2010, the *Long-Term Care Homes Act* (LTCHA) replaced legislation governing long-term care homes including the *Nursing Homes Act*, *Charitable Institutions Act* and *Homes for the Aged and Rest Homes Act*.\(^\text{216}\) The LTCHA carried over some of the protections of the previous acts, but it also created new rules and protections against abuse and neglect.\(^\text{217}\) LTCHA sets out as its fundamental principle that a long-term care home is “a place where [residents] may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met.”\(^\text{218}\)

Set out in section 3 of the LTCHA, the *Residents’ Bill of Rights* offers express protections

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\(^{215}\) This section draws in part from C Tess Sheldon, “Conflicting Issues of Consent and Abuse in Long Term Care Practice: The Value of a Rights Based Approach” (Paper delivered at the Canadian Bar Association’s Health Law Summit, Halifax NS, 24 May 2013).

\(^{216}\) LTCHA, *supra* note 27.

\(^{217}\) Graham Webb, *The Prevention of Abuse and Neglect in Ontario’s Long-Term Care Homes* (Toronto: ACE, 2013), online: Advocacy Centre for the Elderly <www.acelaw.ca/appimages/file/Prevention%20of%20Abuse%20&%20Neglect%20in%20LTC-2013.pdf> at 4: “The new Act carries over some important protections that have long been in effect for long-term care residents, and creates some new protections against abuse and neglect that in some ways change the ground rules for the operation of long-term care homes. Among these long-standing and new measures are strong statements of principles that denounce abuse and neglect; the screening, orientation and training of long-term care home staff and volunteers; zero-tolerance of abuse and neglect; measures addressing responsive behaviours; the provision of specialized units; the mandatory reporting of abuse and neglect; and whistle-blowing protection.”

\(^{218}\) LTCHA, *supra* note 27 at s 1: “The fundamental principle to be applied in the interpretation of this Act and anything required or permitted under this Act is that a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met.”
against abuse and neglect;\textsuperscript{219} these protections are further refined by the LTCHA’s Regulation.\textsuperscript{220} While the \textit{Bill of Rights} does not include any provisions that specifically govern the covert administration of medication, the \textit{Residents’ Bill of Rights} includes the following protections:

2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
11. Every resident has the right to .... ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent.\textsuperscript{221}

The LTCHA offers a broad definition of abuse\textsuperscript{222}, and its Regulation provides that physical abuse includes “administering or withholding a drug for an inappropriate purpose.”\textsuperscript{223} Advocacy Centre for the Elderly (ACE) and Community Legal Education Ontario (CLEO) defined “physical abuse” to include inappropriate medication practice:

Physical abuse is when someone assaults you, handles you roughly, or slaps, pushes, or beats you. It is also physical abuse when someone refuses to give you medicine that you should take, or gives you medicine that you should not be taking.\textsuperscript{224}

“Neglect” is set out by the LTCHA Regulation as the failure to provide a resident with the

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\textsuperscript{219} LTCHA, \textit{supra} note 27 at ss 3(1.2) and 3(1.3).
\textsuperscript{220} LTCHA Regulation, \textit{supra} note 30.
\textsuperscript{221} LTCHA, \textit{supra} note 27 at s 3.
\textsuperscript{222} LTCHA, \textit{supra} note 27 at s 2(1).
\textsuperscript{223} LTCHA Regulation, \textit{supra} note 30 at s 2(1). “Physical abuse” means, subject to subsection (2), (a) the use of physical force by anyone other than a resident that causes physical injury or pain, (b) administering or withholding a drug for an inappropriate purpose, or (c) the use of physical force by a resident that causes physical injury to another resident.
\textsuperscript{224} Advocacy Centre for the Elderly (ACE) & Community Legal Education Ontario (CLEO), “Every Resident: Bill of Rights for People who Live in Ontario Long Term Care Homes” (Toronto: ACE and CLEO, 2011), online: CLEO <www.cleo.on.ca/en/publications/everyres> at 2 [emphasis added]. See also the definition of neglect at page 3: “Neglect is when the home fails to give you the treatment, care, services, or help that you need for your health, safety, or well-being. Neglect also happens when someone, by not taking action, puts your health, safety, or well-being at risk. For example, you have the right to get medication that is prescribed for you. If you need help getting to the toilet, you should be taken to the washroom instead of being forced to use incontinence products such as diapers, pads, or plastic pants.”
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“treatment, care, services or assistance required for health, safety or well-being.” It also includes inaction or a pattern of inaction that jeopardizes residents’ health, safety or well-being.\textsuperscript{225} The Ontario Elder Abuse Prevention Network defined “neglect” to include inappropriate medication practices:

Forms of neglect include: withholding or inadequate provision of physical requirements, such as food, housing, medicine, clothing or physical aids; inadequate hygiene; inadequate supervision/safety precautions; withholding medical services, including medications; overmedicating; allowing a senior to live in unsanitary or poorly heated conditions; denying access to necessary services (e.g. homemaking, nursing, social work, etc.) or denial of a senior’s basic rights.\textsuperscript{226}

The Regulation protects residents against abuse by “anyone” and not just abuse by the long-term care home or its staff. The protections against “neglect” only apply to the licensee and the staff.\textsuperscript{227} These rights form a deemed contract between the resident and the licensee\textsuperscript{228} and may be enforced though a civil action for breach of contract.\textsuperscript{229}

Long-term care homes must develop and implement a mission statement that is consistent with the \textit{Bill of Rights}, including its protections against abuse and neglect.\textsuperscript{230} Homes are required to develop a written policy to promote zero tolerance of abuse and

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\textsuperscript{225} LTCHA Regulation, \textit{supra} note 30 at s 2(1): “‘Neglect’ means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”
\textsuperscript{226} Ontario Network for the Prevention of Elder Abuse, “About Elder Abuse”, online: ONPEA <www.onpea.org/english/elderabuse/formselderabuse.html> [emphasis added].
\textsuperscript{227} LTCHA, \textit{supra} note 27 at s 19 (1): “Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.”
\textsuperscript{228} LTCHA, \textit{supra} note 27 s 3.3: “A resident may enforce the Residents’ Bill of Rights against the licensee as though the resident and the licensee had entered into a contract under which the licensee had agreed to fully respect and promote all of the rights set out in the Residents’ Bill of Rights.”
\textsuperscript{229} LCO Framework - Older Adults (April 2012), \textit{supra} note 123 at 150: “Under the LTCHA, these rights are subject of a deemed contract between the resident and the licensee. Enforcement of these rights would therefore take the form of an action against the licensees for breach of contract.”
\textsuperscript{230} LTCHA, \textit{supra} note 27 at s 4(2).
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neglect of residents and to ensure compliance with that policy.\textsuperscript{231} The Regulation provides detail about the policy’s requirements,\textsuperscript{232} including notification and reporting requirements.\textsuperscript{233} Staff providing direct care to residents must also receive training and re-training in abuse recognition and prevention.\textsuperscript{234}

Section 29 of the LTCHA requires that long-term care homes must have a written policy governing the minimization of restraint use.\textsuperscript{235} The LTCHA Regulation considers the use of restraints in long-term care homes separately from the requirements with respect to abuse and neglect.\textsuperscript{236} Protections from the use of restraints are also set out in the Bill of

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\item LTCHA, supra note 27 at s 20(1): “Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.”
\item LTCHA Regulation, supra note 30 at s 96: “Every licensee of a long-term care home shall ensure that the licensee’s written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
\item (a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
\item (b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
\item (c) identifies measures and strategies to prevent abuse and neglect;
\item (d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
\item (e) identifies the training and retraining requirements for all staff, including,
\item (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
\item (ii) situations that may lead to abuse and neglect and how to avoid such situations.
\item Ministry of Health and Long Term Care, A Guide to the Long-Term Care Homes Act, 2007 and Regulation 79/10 (Toronto: Government of Ontario, 2010), online: MOHLTC <www.health.gov.on.ca/en/public/programs/ltc/docs/ltcha_guide_phase1.pdf> at 2-65 [MOHLTC Guide to the LTHCA]. The requirement to notify a resident’s SDM applies even if the resident has indicated that he or she does not wish to have the SDM notified. See also ACE’s submissions on the proposed amendments to exempt licensees from notifying the SDM where they are the alleged abuser: Advocacy Centre for the Elderly (ACE) Proposed Amendments to the Ontario Regulation 79/10 under the Long-Term Care Homes Act (5 May 2011), online: ACE <www.advocacycentreelderly.org/appimages/file/Submission%20to%20LTCHA%20Proposed%20Amen
dments%20to%20Reg%205_05_11..pdf > at 3.
\item LTCHA, supra note 30 at s 96(e).
\item LTCHA Regulation, supra note 27 at s 29.
\item LTCHA Regulation, supra note 30 at s 2(2): “For the purposes of clause (a) of the definition of “physical abuse” in subsection (1), physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances.”
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Rights. Restraining a resident for the purposes of administering a drug is prohibited, except where the resident may be restrained under the common law duty. The common law duty of restraint includes the duty of an HCP to order the administration of a drug for the purposes of restraining a resident when immediate action is necessary to prevent serious bodily harm to the resident or to others. HCPs, including physicians or nurses, may order the administration of the chemical restraint. Ontario's Guide to the Long Term Care Homes Act and Regulation 79/10 limits the reliance on the common law duty as follows:

Use of the common law duty should not be a routine part of any plan of care. The common law duty enables the Home to address unexpected occurrences in order to prevent serious bodily harm to the resident or to others. It is not be used for any other reason.

The common law duty to restrain is confined to those situations where restraint is used to prevent serious and immediate bodily harm to an individual or others. As such, the duty cannot be invoked to compel or force routine medications.

II. INTERNATIONAL LEGAL MATERIALS

International legal arguments may also support the claims of persons whose medication was covertly administered to them. Gostin and Gable (2004) described international human rights law as a powerful, but often neglected, tool to advance public mental health.

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237 LTCHA, supra note 27 at s 3(1).13: “Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.”

238 MOHLTC Guide to the LTCHA, supra note 233 at 2-112.

239 LTCHA, supra note 27 at s 36.

240 LTCHA, supra note 27 at s 36(3).

241 LTCHA Regulation, supra note 30 at s 137(1).

242 MOHLTC Guide to the LTHCA, supra note 233 at 2-87.

243 Gostin & Gable (2004), supra note 52 at 115: “Attention to mental health issues by public health agencies is integral to the realization of the right to mental health. Since most public health activity takes place at the local level, the incorporation of human rights norms into local policies and procedures may present a promising approach to using human rights standards to support the goals of public mental
The modern era of human rights law began with the adoption of the *Universal Declaration of Human Rights (UDHR)* in 1948. Although disability - including mental health - is not explicitly mentioned among the prohibited grounds for discrimination under Articles 1 or 2 of the UDHR, "disability is presumed to be included in the concept of "other status" and is, therefore, one of the prohibited grounds of distinction."  

The *International Covenant on Civil and Political Rights (ICCPR)* and the *International Covenant on Economic, Social, and Cultural Rights (ICESCR)* are core UN human rights conventions. Together with the UDHR, they make up the "International Bill of Human Rights." The ICCPR and the ICESCR were ratified by Canada in 1976.

ICCPR’s Article 7 prohibits torture and cruel, inhuman or degrading punishment. Article 9 recognizes the rights to liberty and security of the person. It prohibits arbitrary arrest and detention, requires any deprivation of liberty to be according to law, and obliges State Parties to allow those deprived of their liberty to challenge their imprisonment through the courts. These provisions also apply to persons detained in psychiatric

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245 *Progress of Efforts to Ensure the Full Recognition and Enjoyment of the Human Rights of Persons with Disabilities – Report of the Secretary General*, UNGAOR, 58th Sess, UN Doc A/58/181 (24 July 2003) at para 8: "The Universal Declaration of Human Rights, in Articles 1 and 2, states that all human beings are born free and equal in dignity and rights and are entitled to all the rights and freedoms set forth in the Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Although disability is not explicitly mentioned among the prohibited grounds for discrimination, it is included in the concept of "other status" and is therefore one of the prohibited grounds of distinction."


249 ICCPR, *supra* note 246 at Article 9.4.
institutions. Article 10 of the ICCPR requires anyone deprived of liberty to be treated with dignity and humanity. Article 14 of the ICCPR recognizes and protects a right to justice and a fair trial.

The ICESCR includes a right to self-determination (Article 1) and the right to the highest attainable standard of physical and mental health, including the right to health care (Article 12). This right is expressed in General Comment 14:

The right to health contains both freedoms and entitlements. The freedoms include the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection, which provides equality of opportunity for people to enjoy the highest attainable level of health.

Article 2 requires States to guarantee that all ICESCR rights are exercised without discrimination, including on the ground of disability. In its General Comment 5, the Committee on Economic, Social and Cultural Rights elaborated on access to medical and social services:

All such services should be provided in such a way that the persons concerned are able to maintain full respect for their rights and dignity.

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250 General Comment 8: Article 9 (Right to Liberty and Security of Persons), CCPR, 16th Sess, (30 June 1982) at para 1: “The Committee points out that paragraph 1 is applicable to all deprivations of liberty, whether in criminal cases or in other cases such as, for example, mental illness, vagrancy, drug addiction, educational purposes, immigration control, etc.” See also General Comment 21: Replaces General Comment 9 Concerning Humane Treatment of Persons Deprived of Liberty, CCPR, 54th Sess, UN Doc 04/10/1992 (10 April 1992) at para 1: “...applies to any one deprived of liberty under the laws and authority of the State who is held in prisons, hospitals - particularly psychiatric hospitals.”

251 General Comment 14, supra note 134 at para 8 [emphasis added].

252 General Comment 5: Persons with Disabilities, CESR, 11th Sess, UN Doc 12/09/1994 (9 December 1994) at para 34: “The right to physical and mental health also implies the right to have access to, and to benefit from, those medical and social services - including orthopedic devices - which enable persons with disabilities to become independent, prevent further disabilities and support their social integration. ...”
In 1991, the United Nations General Assembly adopted the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (MI Principles)*.\(^{253}\) The *MI Principles* set out the minimum human rights standards owed to persons with mental disabilities. It is a non-binding instrument. The *MI Principles* provide detailed procedural protections for persons receiving psychiatric services. The following principles are relevant to the covert administration of medication:

- Principle 8.2 protects patients from harm, including “unjustified medication”.
- Principle 9.1 expresses that patients have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to their health needs and to ensure the physical safety of others.
- Principle 9.3 requires that mental health care shall be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the *Principles of Medical Ethics adopted by the United Nations General Assembly*.
- Principle 9.4 provides that the treatment of every patient shall be directed towards preserving and enhancing personal autonomy.
- Principle 10.1 requires that medication shall meet the best health needs of the patient, shall be given to a patient only for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others.
- Principle 11.11 declares that physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond a period strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them, and their nature and extent shall be recorded in the patient’s medical record. A patient who is restrained or secluded shall be kept under humane conditions and

\(^{253}\) *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, GA Res 119, GAOR, 46th Sess, Supp No 49, UN Doc A/46/49 (17 December 1991) [MI Principles].*
be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.

The MI Principles, particularly Principle 11, have been criticized for setting standards too low. Some advocates claim that the MI Principles are inconsistent with existing human rights standards, particularly in the context of involuntary treatment and detention.254

The World Medical Assembly (WMA) adopted the Declaration on the Rights of the Patient in 1981; this document was revised in 2005. The Declaration includes protections of the right to self-determination (section 3) and the duty to obtain informed consent (section 4 and 5).255 It also emphasizes the right to information, as outlined below:

> Exceptionally, information may be withheld from the patient when there is good reason to believe that this information would create a serious hazard to his/her life or health.256

The Standard Rules on the Equalization of Opportunities for Persons with Disabilities (Standard Rules) were adopted in 1994, following the UN Decade of Disabled Persons (1983-1992).257 The Standard Rules established the office of the Special Rapporteur on Disability who is responsible for monitoring compliance with the Rules. The Rules set out

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254 Report of the Secretary General, supra note 245 at para 13: “Furthermore, [the MI Principles] offer in some cases a lesser degree of protection than that offered by existing human rights treaties, for example with regard to the requirement for prior informed consent to treatment. In this regard, some organizations of persons with disabilities, including the World Network of Users and Survivors of Psychiatry, have called into question the protection afforded by the Principles (and in particular, principles 11 and 16) and their consistency with existing human rights standards in the context of involuntary treatment and detention.”


256 WMA Declaration, supra note 255 at s 7.

detailed provisions to ensure that persons with disabilities are able to exercise the same rights as other persons. The preamble to the Standard Rules sets out a broad definition of disability to include the experience of mental illness.\textsuperscript{258} Rule 2 provides that States should ensure that persons with disabilities are provided with the regular treatment and medicines they need to preserve or improve their level of functioning.\textsuperscript{259}

The \textit{Convention on the Rights of Persons with Disabilities} (CRPD) and its Optional Protocol were adopted in December 2006 and were opened for signature in March 2007.\textsuperscript{260} At present, there are 147 signatories to the Convention (including Canada) and 82 signatories to the Optional Protocol. The CRPD on its opening day received the highest number of signatories in UN Convention history.\textsuperscript{261} Remarkably, the CRPD was the fastest negotiated human rights treaty. Canada ratified the CRPD in March 2010 with a reservation relevant to the implementation of the supported decision making provisions.\textsuperscript{262} The CRPD has “ushered in a new era of disability rights policy.”\textsuperscript{263}

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\item \textsuperscript{258} Rules, \textit{supra} note 257 at “Introduction”: “The term 'disability' summarizes a great number of different functional limitations occurring in any population ... People may be disabled by physical, intellectual or sensory impairment, medical conditions or mental illness. Such impairments, conditions or illnesses may be permanent or transitory in nature.”
\item \textsuperscript{259} Rules, \textit{supra} note 257 at Rule 2: “Medical care: ... States should ensure that persons with disabilities are provided with any regular treatment and medicines they may need to preserve or improve their level of functioning.”
\item \textsuperscript{260} CRPD, \textit{supra} note 108.
\item \textsuperscript{261} UN Enable, "Convention on the Rights of Persons with Disabilities", online: UN <\url{www.un.org/disabilities/default.asp?navid=15&pid=150}.
\item \textsuperscript{262} CRPD, \textit{supra} note 108. Canada ratified the CRPD in March 2010, with a reservation relevant to the implementation of Article 12: “Canada recognizes that persons with disabilities are presumed to have legal capacity on an equal basis with others in all aspects of their lives. Canada declares its understanding that Article 12 permits supported and substitute decision-making arrangements in appropriate circumstances and in accordance with the law. To the extent Article 12 may be interpreted as requiring the elimination of all substitute decision-making arrangements, Canada reserves the right to continue their use in appropriate circumstances and subject to appropriate and effective safeguards. With respect to Article 12 (4), Canada reserves the right not to subject all such measures to regular review by an independent authority, where such measures are already subject to review or appeal.”
\end{footnotes}
The CRPD reaffirms that persons with disabilities – including persons with mental health issues – must enjoy all human rights and fundamental freedoms. It identifies areas where accommodations must be made for persons with disabilities to effectively exercise their rights. The Office of the High Commissioner for Human Rights characterizes the CRPD as “enshrining the social and human rights model of disability.”

The principle of autonomy “pervades” the CRPD and “underpins many of the freedoms that it explicitly recognizes.” Article 3 of the CRPD proclaims the importance of the principle of respect for the individual autonomy of persons with disabilities. The Office of the High Commissioner for Human Rights (2010) outlined these expectations:

> Individual autonomy means to be in charge of one’s own life and to have the freedom to make one’s own choices. Respect for the individual autonomy of persons with disabilities means that persons with disabilities have, on an equal basis with others, reasonable life choices, are subject to minimum interference in their private life and can make their own decisions, with adequate support where required. ...From this perspective, for example, a person with mental disabilities should be offered a range of options for mental health care such as psychotherapy, counseling, peer support and psychiatric medication, and should have the freedom to make a meaningful choice based on personal preferences.

The right to equal recognition before the law (Article 5) also applies to capacity determinations that underlie the covert administration of medication. The Office of the High Commissioner of Human Rights (2010) described alternative ways of understanding legal capacity:

> The right to equal recognition before the law requires, inter alia, eliminating disability as a ground for depriving someone of his or her legal capacity—for example, by eliminating the practice of appointing guardians who make decisions on behalf of persons with disabilities and, instead, providing

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265 Office of the High Commissioner for Human Rights, supra note 264 at 19.
266 Office of the High Commissioner for Human Rights, supra note 264 at 19.
support to persons with disabilities so that they can make their own decisions.267

Article 12 recognizes that persons with disabilities have equal right to enjoy legal capacity in all areas of life including decisions on where to live and whether to accept medical treatment. Article 12 “requires that all people, regardless of disability, be accorded the right to make their own decisions and be provided the support required to exercise their decision-making autonomy.”268 Anticipating that Article 12 may be interpreted to require the adoption of supported decision-making models, Canada reserved the right to continue the use of substitute decision-making models.269

Article 25 of the CRPD provides a “right to health”. Article 25 recognizes that medical care of persons with disabilities must be based on their free and informed consent. In general terms, the Office of the High Commissioner of Human Rights (2010) explains that

The right to health requires, inter alia, not only an examination of whether there is universal access to essential medicines but also whether treatments are provided on the basis of the free and informed consent of the person with a disability.270

Article 15 provides that State Parties must ensure that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. The Office of the High Commissioner of Human Rights (2010) elaborated on this notion:

Freedom from torture requires, inter alia, examining whether institutions resort to practices and treatments such as electroshock therapy and cage beds for persons with disabilities, or impose intrusive or irreversible medical treatments aimed at correcting the disability against a person's will.271

269 James & Watts, supra note 268 at 13.
270 Office of the High Commissioner for Human Rights (2010), supra note 264 at 27.
The UN adopted the *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (CAT) in 1984.²⁷² Perlin and Schriver (2013) proposed that the CRPD must be “read hand-in-glove” with the CAT.²⁷³ Article 2 requires State parties to take effective measures to prevent torture, and Article 16 sets out that that actions that fall short of torture may still constitute cruel, inhuman or degrading treatment. Lord (2010) posited that the prohibitions against torture “must be regarded as having attained the status of customary international law.”²⁷⁴

In his 2013 Report, the Special Rapporteur on Torture called for an absolute ban on restraint, solitary confinement, and the nonconsensual administration of electroshock, psychosurgery and neuroleptics. His report aimed to “shed light on often undetected forms of abusive practices that occur under the auspices of health-care policies.”²⁷⁵

As the Special Rapporteur on the right to health observed, while informed consent is commonly enshrined in the legal framework at the national level, it is frequently compromised in the health-care setting. Structural inequalities, such as the power imbalance between doctors and patients, exacerbated by stigma and discrimination, result in individuals from certain groups being disproportionately vulnerable to having informed consent compromised.²⁷⁶

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²⁷² *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 10 December 1984, 1465 UNTS 113, 19 ILM 33 (entered into force 26 June 1987).
²⁷⁵ *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, HRC, 22nd Session, UN Doc A/HCR/22/53 (1 February 2013) at 1: “By illustrating some of these abusive practices in health-care settings, the report sheds light on often undetected forms of abusive practices that occur under the auspices of health-care policies, and emphasizes how certain treatments run afoul of the prohibition on torture and ill-treatment.”
The Special Rapporteur continued on to find that informed consent must be provided for all treatment, except in a life-threatening emergency procedure.\(^{277}\)

In his 2008 interim report to the UN General Assembly, the Special Rapporteur wrote that forced and non-consensual administration of psychiatric drugs, particularly neuroleptics, must be closely scrutinized. Depending on the circumstances of the case, non-consensual treatment may constitute a form of torture or ill-treatment.\(^{278}\) He also found that there can be no therapeutic justification for the prolonged use of restraints and that this may amount to torture or ill-treatment.\(^{279}\)

### III. Highlights – Canadian Jurisprudence

Arranged thematically, this section reviews influential cases that address some of the legal issues relevant to the covert administration of medication. This selected caselaw, for example, offers direction about the constitutionality of forced treatment, the determination of the capacity to consent to treatment and the scope of the duty to obtain informed consent. A more extensive review of the caselaw is beyond the scope of this chapter.

\(^{277}\) Special Rapporteur-Torture (2013), supra note 275 at para 66: “As earlier stated by the mandate, criteria that determine the grounds upon which treatment can be administered in the absence of free and informed consent should be clarified in the law, and no distinction between persons with or without disabilities should be made. Only in a life-threatening emergency in which there is no disagreement regarding absence of legal capacity may a health-care provider proceed without informed consent to perform a life-saving procedure. From this perspective, several of the 1991 Principles [MI Principles] may require reconsideration as running counter to the provisions of the Convention on the Rights of Persons with Disabilities.”

\(^{278}\) Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, UNGAOR 63 Sess, UN Doc A/63/175 (28 July 2008) at para 63: “The Special Rapporteur notes that forced and non-consensual administration of psychiatric drugs, and in particular of neuroleptics, for the treatment of a mental condition needs to be closely scrutinized. Depending on the circumstances of the case, the suffering inflicted and the effects upon the individual's health may constitute a form of torture or ill-treatment.”

\(^{279}\) Special Rapporteur–Torture (2008), supra note 278 at para 55.
i) With Protections, Forced Treatment May Not Offend the *Charter*

Challenges to mental health legislation, including their provisions that authorize non-consensual treatment, have relied on the *Charter of Rights and Freedoms*. In particular, non-consensual treatment may engage Section 7 ("Life, liberty and security of person").\(^{280}\) Section 12 ("Treatment or punishment")\(^{281}\) and Section 15 ("Equality before and under law and equal protection and benefit of law").\(^{282}\)

In *Fleming v Reid* (1991), the Ontario Court of Appeal considered that constitutionality of legislation authorizing non-consensual treatment.\(^{283}\) Two patients were involuntarily admitted to a psychiatric hospital. Their physician found that they were incapable of making treatment decisions and proposed the administration of anti-psychotic medication. While capable of making treatment decisions, both patients had previously refused anti-psychotic medications because of their side effects. Given the patients’ prior capable wishes, the substitute decision-maker (the public guardian) refused to consent to the physician’s proposed treatment. The physician appealed the SDM’s decision. The Ontario Court of Appeal found that the forced treatment of a person incapable of making treatment decisions is permissible only where the prior capable wishes guide substitute decision makers. The Court considered the common law rule that there may be no treatment without consent. Any legislation that authorizes such treatment must comport with the "principles of fundamental justice" set out by section 7 of *Charter*. The Court found that Section 7’s minimal protections demand that a person’s prior wishes (where known) must guide substitute decision-making.

\(^{280}\) *Charter, supra* note 105 at s 7: “Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.”

\(^{281}\) *Charter, supra* note 105 at s 12: “Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.”

\(^{282}\) *Charter, supra* note 105 at s 15(1): “Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.”

ii) The Determination of Treatment Capacity Must be Contextually Driven

The determination of capacity does not depend on “best interests.” Instead, the determination of capacity to consent to treatment must be contextually based.

In Starson v Swayze (2003), the Supreme Court of Canada overturned the decision of the CCB that the applicant, Professor Starson, was incapable of making treatment decisions.284 Professor Starson was admitted to hospital; his physicians proposed treatment for bipolar disorder, which Professor Starson refused. The physician found that he was not capable of consenting to treatment. Professor Starson applied to the CCB for a review of the physician’s decision. The CCB confirmed his incapacity.

Justice Major authored the majority opinion of the Supreme Court. He found that capacity involves two criteria: first, a person must be able to understand the information that is relevant to making a treatment decision and, second, a person must be able to appreciate the reasonably foreseeable consequences of the decision or lack of one.285 Although Professor Starson did not view his mental health issues as illness, he understood that his brain functioned differently. He also appreciated the intended effects of the medication. Apart from whether Professor Starson did not in fact appreciate the risks and benefits of treatment, the CCB did not consider whether Professor Starson was able to appreciate those risks and benefits. The wisdom of his treatment decision is irrelevant to the determination of capacity.286 For the majority of the Court, Justice Major found that the CCB improperly allowed its own conception of Professor Starson’s best

285 Starson v Swayze, supra note 284 at para 78: “[c]apacity involves two criteria. First, a person must be able to understand the information that is relevant to making a treatment decision. This requires the cognitive ability to process, retain and understand the relevant information. There is no doubt that the respondent satisfied this criterion. Second, a person must be able to appreciate the reasonably foreseeable consequences of the decision or lack of one. This requires the patient to be able to apply the relevant information to his or her circumstances, and to be able to weigh the foreseeable risks and benefits of a decision or lack thereof.”
286 Starson v Swayze, supra note 284 at para 112: “The Board’s sole task was to determine the patient’s mental capacity. The wisdom of Professor Starson’s treatment decision is irrelevant to that determination.”
interests to influence its finding of incapacity. The majority found that the wisdom of Professor Starson’s treatment decision is irrelevant to that determination.

Chief Justice McLachlin wrote a dissent for a minority of the Court in Starson. She found that the issue was not whether the CCB’s conclusion was the best conclusion on the evidence but rather whether it is amongst the range of possible conclusions that the CCB could reasonably have reached.\footnote{\textit{Starson v Swayze}, supra note 284 at para 23: “The issue here is not whether the Board’s conclusion was the best conclusion on the evidence. It is rather whether it is among the range of conclusions that the Board could reasonably have reached.”}

In \textit{AC v Manitoba} (2009), the Supreme Court of Canada considered a challenge to a provincial legislative scheme that presumed that persons under 16 years of age are incapable of making treatment decisions.\footnote{\textit{AC v Manitoba (Director of Child and Family Services)}, 2009 SCC 30, [2009] 2 SCR 181 (Lexum).} The 15-year old claimant refused blood transfusions because of her religious beliefs. During a medical emergency, she was taken into the care of a children’s aid organization that adopted a “best interest” approach to making treatment decisions on her behalf. The organization sought a treatment order under the Manitoba \textit{Child and Family Services Act}. The Superior Court ordered it was in her “best interests” to receive blood transfusions. The applicant and her parents appealed the order arguing that the legislative scheme was unconstitutional.

The Supreme Court found that the impugned sections of the \textit{Child and Family Services Act} were constitutional. The Court rendered three decisions. Justice Abella wrote for the majority of the Court. The “best interests” standard in the \textit{Child and Family Services Act} operates as a “sliding scale of scrutiny” with the child’s views becoming increasingly determinative depending on her maturity. When the “best interests” standard is properly interpreted, the legislative scheme created by the \textit{Child and Family Services Act} does not offend the \textit{Charter}. The majority of the Supreme Court confirmed that the law does not recognize a specific age of consent. Rather, it holds that capacity or lack of
capacity is a function of a number of factors including the maturity of the individual and the complexity of the decision to be made.

Justice Binnie wrote a strong dissenting judgement, finding that “[f]orced medical procedures must be one of the most egregious violations of a person's physical and psychological integrity.” 289 He found that the Child and Family Services Act is unconstitutional because it prevents a person under 16 years of age from establishing her capacity. The presumption of her incapacity to consent to or refuse medical treatment violated her freedom of religion (Section 2 of the Charter) and her right not to be deprived of her liberty or security of the person (Section 7 of the Charter).

iii) Application of Restraints to Effect Treatment May Not Offend the Charter

There are emergent questions about the application of the HCCA to the use of restraints to effect treatment. In particular, there are outstanding questions about whether restraints require separate and additional consent from the consent to the treatment.

An appeal from the CCB, the Ontario Superior Court in SMT v Abouelnasr (2008) considered the constitutionality of the use of physical restraints - for the purpose of administering medication to persons who have been determined to be incapable of making treatment decisions. 290 Mr. SMT was a long-term inpatient who had been determined to be incapable of making treatment decisions. His sister consented to the physician’s proposed treatment of long-acting anti-psychotic medication delivered intramuscularly (IM) by injection. Mr. SMT became upset after he was advised that his sister had consented to the IM injection; he was involuntarily admitted to the Whitby Mental Health Centre (now known as Ontario Shores). On two occasions, Mr. SMT was physically restrained during the IM administration of the anti-psychotic medication. Mr. SMT argued that the HCCA provisions authorizing treatment with restraints constituted

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289 AC v Manitoba, supra note 288 at para 67.
290 SMT v Abouelnasr, [2008] 0 J No 1298, 171 CRR (2d) 344, 166 ACWS (3d) 569 (QL) (Sup Ct).
a breach of Section 7 of the Charter. Mr. SMT also argued that the provisions were in violation of Section 15 of the Charter and discriminated against people with mental health issues. He additionally argued that the HCCA provisions that permitted non-consensual treatment amounted to “cruel and unusual treatment or punishment”, in violation of Section 12 of the Charter.

For the Divisional Court, Justice Lack found that the CCB had not erred in its finding that Mr. SMT was incapable of making treatment decisions and that he met the criteria for involuntary admission. Justice Lack found that the HCCA provisions that authorized non-consensual treatment with restraints “engaged” Section 7, but that HCCA’s procedural protections “exceed the minimal constitutional protections.” Justice Lack offered brief attention to the applicant’s s. 15 arguments, defining the comparator group as “other groups of incapable persons upon receiving treatment on substitute consent.” The Court also found that the use of physical restraints used to administer treatment consented to by an SDM constituted part of a “treatment plan” for the purposes of the HCCA. Justice Lack found that the use of restraint amounts to “treatment” within the meaning of the HCCA:

This is a convenient point to note that counsel for the appellant argues that “restraint” is not included in the definition of “treatment” under the Health Care Consent Act. I do not accept this submission. The definition of “treatment” in the Act includes “anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose.” 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

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291 SMT (2008), supra note 290 at para 55. See also para 57: “The provisions which authorize the administration of treatment without personal consent where the person is incapable and a substitute decision maker provides consent are not ambiguous or vague. They are not arbitrary. They plainly further the purpose of the Health Care Consent Act of promoting the autonomy of capable persons to consent to or refuse treatment and protecting the welfare of persons who would benefit from treatment, but who are incapable of giving consent.”

292 SMT (2008), supra note 290 at para 62: “There is simply no evidence that people with mental illness subject to forcible treatment pursuant to substituted consent are treated differently than other groups of incapable persons upon receiving treatment on substituted consent.”
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.\textsuperscript{293}

While the Court is not explicit, SMT may be interpreted to support an argument that an SDM is deemed to have consented to a “plan of treatment” which includes the use of restraints.\textsuperscript{294} SMT appears to stand for the proposition that HCPs are permitted to consider the use of restraints to effect treatment, where that treatment has been properly consented to by an SDM.\textsuperscript{295}

iv) Availability of Claims of Assault, Battery and False Imprisonment

There is emergent caselaw about HCP’s exposure to civil and criminal charges of battery, false imprisonment or fraud. While these decisions do not raise issues specific to the practice of the covert administration of medication, they stand for the proposition that such civil claims are available in psychiatric settings.

\textit{VAH v Lynch} (2008) stands for the proposition that an HCP may be subject to claims of false imprisonment, battery and/or assault where she fails to obtain informed consent from a person under psychiatric care\textsuperscript{296}. The appellant, experiencing post-partum psychosis, consented to psychiatric treatment but allegedly withdrew her consent. She

\begin{footnotesize}
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\item\textsuperscript{293} SMT (2008), supra note 290 at para 53[emphasis added].
\item\textsuperscript{294} Barbara Walker-Renshaw, “Restraint to Facilitate Treatment: Is it Compatible with Least Restraint Principles?” (2009) 4:1 JEMH at 3: “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.” [emphasis added].
\item\textsuperscript{295} Walker-Renshaw (2009), supra note 294 at 4: “The 2008 SMT 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 nonconsensual treatment, lawfully consented to by an SDM. 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 autonomy of capable persons, but also protecting the welfare of persons who would benefit from treatment, but who are incapable of giving consent.”
\item\textsuperscript{296} VAH v Lynch, 2009 ABCA 221, [2009] AJ No 1397, 460 AR 374, 178 ACWS (3d) 251 (QL) (Alberta Court of Appeal).
\end{itemize}
\end{footnotesize}
was physically restrained and administered antipsychotics by injection. The Alberta Court of the Queen’s Bench found that a claim of assault or battery might be made out where an HCP fails to obtain informed consent. The tort of assault arises when conduct gives rise to a reasonable apprehension of imminent harm.297 “Battery” is defined as a “direct, intentional and physical interference with the person that is either harmful or offensive to a reasonable person.”298 The Court reviewed jurisprudence about the claims of false imprisonment and assault/battery in the psychiatric system, and found that the appellant did not clearly and unequivocally withdraw her consent since her expression of a desire to leave was interspersed with “bizarre behaviour”.299 Her consent was a complete bar to her claims of battery, assault and false imprisonment.

In Dr. X v Everson (2013), the Ontario Superior Court awarded Dr. X damages for negligence and false imprisonment.300 Dr. X, a cardiologist, had her first baby in 2005. She was very anxious about her infant’s gastroenterological health as well as the lack of a definitive diagnosis. Dr. X sought referrals to pediatric specialists as well as the assistance of Dr. Everson, a senior physician who was also Dr. X’s supervisor, to arrange an urgent referral to a pediatric specialist. Dr. X contacted Dr. Everson on multiple occasions. Dr. Everson, concerned for Dr. X's wellbeing, obtained information from Dr. X's family physician, including details concerning a sedative prescribed to Dr. X. At a meeting between Dr. X and Dr. Everson, believed by Dr. X to be about a referral to a pediatric specialist, Dr. X was advised that Dr. Everson had prepared an Application for Psychiatric Assessment (Form 3). Dr. X was taken to a nearby hospital against her will. Dr. X pursued general damages for mental suffering and special damages for loss of income resulting from the defendant’s negligence and false imprisonment, specifically in relation to the decision to “form” her. Justice Reid found that Dr. Everson’s failure to check the reliability of third-party information from Dr. X’s physician resulted in an improper completion of Application for Psychiatric Assessment (Form 1). Accordingly,

297 VAH v Lynch, supra note 296 at para 259.
298 VAH v Lynch, supra note 296 at para 260.
299 VAH v Lynch, supra note 296 at paras 407 to 411.
300 Dr X v Everson, 2013 ONSC 6134, [2013] OJ No 4504, 4 CCLT (4th) 205 (QL) (Sup Ct).
the plaintiff’s detention was not authorized by law and constituted “false imprisonment.”

v) Mental Health Tribunals Have Tangentially Approached Covert Medication

Ontario courts and tribunals have not explicitly considered a challenge raised by the covert administration of medication. The practice remains untested by courts, possibly given barriers to potential claimants bringing such challenges, including where neither the patient nor the SDM are aware of the fact of the covert administration of medication. In following decisions of the Consent and Capacity Board (CCB) and the Ontario Review Board (ORB), the delivery of medication in food or drink is raised only tangentially.

In CR (Re) (2003), the CCB confirmed the appellant’s involuntary status. Ms. CR was an inpatient who had previously resided in several long-term care settings. The CCB made specific reference to Ms. CR’s belief that the “chef [at the retirement home] was putting medication in food to sedate her.” The CCB also noted that during her most recent admission, CR “believed that hospital staff was putting medications in her food.” The CCB found that CR had “no insight” and believed that “she did not require the psychiatric medications that assist in maintaining her stability.” The CCB relied on CR’s belief “that hospital staff wanted to poison her with medication” as evidence that she would deteriorate after discharge.

In PS (Re) (2004), the CCB reviewed the finding that P.S. was incapable of managing property. The CCB panel heard evidence that Mr. PS made fast food orders daily and had them delivered by taxi. Mr. PS claimed that the hospital was putting medication in his food since he was not allowed to choose his own food tray from a number of trays at the

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301 Dr X, supra note 300 at para 194: “In effect, the Form 1 was completed outside the authority of the Act. There is no other statutory or common law authority that would justify the detention in these circumstances. As a result, I find that the defendant has not proven on a balance of probabilities that the detention was justified.”

302 CR (Re), 2003 CanLII 54941 (CANLii) (Ontario Consent and Capacity Board).
cafeteria. His fear about the covert administration of medication was used as evidence of incapacity to manage his finances.\textsuperscript{303}

In \textit{W (Re)} (2005), the CCB upheld the decisions that Mr. W was incapable of making admission or treatment decisions. The CCB relied on Mr. W's fears that medications were hidden in his food and drink as evidence of his incapacity to consent to treatment or to refuse admission to a psychiatric facility. The applicant had discovered that the nursing home staff had covertly administered medication in his prune juice. He stopped eating or drinking, except for canned or sealed foods. Mr. W was later admitted to Whitby Mental Health Centre (now Ontario Shores) where he refused to eat or drink because he thought his food and drink contained poison. The CCB panel heard evidence from his psychiatrist that Mr. W was “very paranoid and delusional” because of his belief that his food and drink were poisoned. Mr. W’s counsel submitted that Mr. W had good reason to be suspicious of his food and drink and the fact the nursing staff hid medication into his juice should be taken into account.\textsuperscript{304}

In \textit{Chaudry (Re)} (2007), the ORB made passing reference to the fact that the accused’s mother was hiding anti-psychotic medication in his food. The ORB did not comment on the ethical or legal implications of the mother’s practice.\textsuperscript{305}

\textsuperscript{303} \textit{PS (Re)}, [2004] OCCBD No 10 (QL) (Ontario Review Board) at para 24: “The Applicant did not think there was any problem in making these daily expenditures in the manner that he did. He insisted that he was forced to make these expenditures because he was not able to eat the hospital food. The Applicant claimed that the hospital was putting medication in his food and since the hospital would not allow him to pick a food tray from a number of trays, this somehow confirmed that they were doing this.”

\textsuperscript{304} \textit{W (Re)}, [2005] OCCBD No 234 (QL)(Ontario Review Board) at para 15: “On June 1, 2005, he was admitted to Whitby as a voluntary patient. He was diagnosed with chronic paranoid schizophrenia and hypertension. He denied that he was mentally ill but he did concede that he was suffering from high blood pressure. He was delusional and suffered from hallucinations. He refused to take his anti-psychotic medications as well as his anti-hypertensive medication for his high blood pressure believing that all his medications contained mercury that would poison him. He was also under nourished and dehydrated because he had stopped eating and drinking at the nursing home prior to his admission to Whitby.”

\textsuperscript{305} \textit{Chaudry (Re)} [2007] ORBD No 224 (QL) (Ontario Review Board) at para 12: "Between the years 2000 and 2006 he had been prescribed antipsychotic medications but was either taking them sporadically or was noncompliant. The accused’s mother tried to convince the accused to take his medication and at times crushed them to hide them in his food."
In *Koundakjian (Re)* (2010), the ORB reviewed the accused’s disposition order. The ORB upheld the order, finding he had a history of poor or no insight and a history of non-compliance and “would discontinue the use of medication resulting in an illness relapse.” In its order, the ORB excerpted the hospital’s report finding that his family members had relied on “coercive measures such as concealing medication in his food.”\(^\text{306}\)

In *Anten v Bhalerao* (2013), the Ontario Court of Appeal considered the finding of incapacity to make treatment decisions.\(^\text{307}\) The Court described the administration of Risperidone (an antipsychotic medication) in the patient’s orange juice, possibly without her knowledge. Neither the Court of Appeal nor the CCB explicitly considered the medication’s form or route.

While mental health tribunals, and reviewing Courts, have considered claims that involve the covert administration of medication, no tribunal or Court has explicitly considered its constitutionality or legality. Instead, the legal issues raised by the practice have only been tangentially considered, often in passing.

\(^{306}\) Koundakjian (Re), [2010] ORBD No 1759 (QL) (Ontario Review Board) at para 22: “The hospital report notes ”...The family's pattern of interaction is one in which Mr. Koundakjian demands their support (largely financial) but then does not comply with the attached expectations, such as operating a store, supporting himself, abstaining from substance abuse, and taking his medication. Family members have historically responded by using more coercive measures such as concealing medication in his food which served to increase Mr. Koundakjian's anger and demands.”

\(^{307}\) Anten v Bhalerao, 2013 ONCA 499, [2013] OJ No 3459, 309 OAC 28, 366 DLR (4th) 370, 229 ACWS (3d) 870 (QL)(Court of Appeal) at para 9: “The respondent's evidence about the medication regime and the effect of that medication on the appellant was confusing. It appeared that the first medication, including the anti-psychotic Risperidone, was at some point given to the appellant in her orange juice, "to improve her compliance". It was unclear when this medication regime began, when the hospital began to give it to her in her orange juice and whether the appellant knew it was in her orange juice. Then, on December 21, the appellant was given Risperidone in an injectable form. However, the appellant objected because of side effects.”
IV. Professional Guidance: Domestic and International

The Canadian Nurses Association (CNA) *Code of Ethics* requires that nurses promote and respect informed decision-making and preserve the dignity of the person receiving care.\(^{308}\) Specifically, the *Code* requires that nurses “do not engage in any form of lying.”\(^{309}\)

The Canadian Medical Association’s (CMA) *Code of Ethics* includes no specific reference to the covert administration of medication although there is an entire section devoted to “Communication, Decision-Making and Consent”. In particular, physicians, residents and medical students must uphold the following standards:

24. Respect the right of a competent patient to accept or reject any medical care recommended.
28. Respect the intentions of an incompetent patient as they were expressed (e.g. though a valid advance directive or proxy designation) before the patient became incompetent.
29. When the intentions of an incompetent patient are unknown and when no formal mechanism for making treatment decisions is in place, render such treatment as you


“C4. Nurses ensure that nursing care is provided with the person’s informed consent....
C9. When illness or other factors reduce a person’s capacity for making choices, nurses assist or support that person’s participation in making choices appropriate to their capability....
C10. If a person’s receiving care is clearly incapable of consent, the nurse respects the law on capacity assessment and substitute decision making in his or her jurisdiction....
C11. Nurses, along with other health care professionals and with substitute decision maker, consider and respect the best interests of the person receiving care and any previously known wishes or advance directives that apply in the situations....
D1. Nurses, in their professional capacity, relate to all persons with respect.
D2. Nurses support the person, family, group, population or community receiving care in maintaining their dignity and integrity....
D4. Nurses intervene, and report when necessary, when others fail to respect the dignity of a person receiving care, recognizing that to be silent and passive is to condone the behavior.”

\(^{309}\) *Code of Ethics for Registered Nurses* (2008), supra note 308 at 17: “F3. Nurses do not engage in any form of lying, punishment or torture or any form of unusual treatment or action that is inhumane or degrading.”
believe to be in accordance with the patient’s values or, if these are unknown, the patient’s best interests.\(^{310}\)

Chapter 5 (“Results”) reviews the results of the Document Review/Analysis, including guidance from professional organizations that include physicians and nurses. Professional organizations of physicians did not offer express guidance about the practice. Three guidance documents from professional nurses associations are reviewed in Chapter 5:

- College of Registered Nurses of Manitoba, “Interpretative Document: Covert Medication Administration – Code of Ethics Application” (2006);\(^{311}\)
- College of Registered Nurses of Nova Scotia, “Medication Guidelines” (2011);\(^{312}\) and
- College of Registered Psychiatric Nurses of British Columbia, “Dose Form Modification” (2011).\(^{313}\)


\(^{311}\) College of Registered Nurses of Manitoba, Interpretative Document: Covert Medication Administration (Winnipeg, CRNM, 2006), online: CRNM <cms.tng-secure.com/file_download.php?File_id=147> at 1: “You are involved in a potentially serious legal and ethical violation that needs to be addressed immediately. ... HCPs are obligated to advocate for patients and work to resolve practice issues such as this one”. The Code of Ethics for Registered Nurses values (amongst others) the principles of choice, dignity and accountability. Nurses must be committed to preserving and promoting the autonomy of clients. A therapeutic relationship is based on trust. If a patient is excluded from decision-making, she will experience a loss of control and increased vulnerability. A nurse is in an ideal position to advocate for the rights of a patient to participate in decision-making about treatment. A nurse must be able to refuse to participate in covert administration without threat of reprisal or discipline.”

\(^{312}\) College of Registered Nurses of Nova Scotia, Medication Guidelines for Registered Nurses (Halifax: CRNNS, 2011), online: CRNNS < www.crnns.ca/documents/MedicationGuidelines.pdf > at 30ff: “This practice disregards a client’s right to informed consent and her/his right to refuse medications. Covert medication administration also breaches client trust, violates the Code of Ethics for Registered Nurses, and is a misuse of a registered nurse’s professional status.”

\(^{313}\) College of Registered Psychiatric Nurses of British Columbia, Dose Form Modification of Medication: Evidence Based Guidelines (Vancouver: CRPNC, 2011), online: CRPNC <www.crpncbc.ca/wp-content/uploads/2011/07/Dose-Form-Modification-of-Medication_2011October.pdf> at 2: “The CRPNC Code of Ethics and Standards of Practice do not support the practice of administering covert medication.” Also see 1: “The practice of crushing, splitting or opening medication (dose form modification) is common in some psychiatric settings and is accompanied by specific risks that can impact the client and Psychiatric Nurse.” Also at 2 “Two common reasons for drug form modification are: 1) To assist a client who has
The Canadian Nurses Protective Society (CNPS) and the Canadian Medical Protective Association (CMPA) provided no specific direction that applies to the covert administration of medication. The Canadian Nurses Protective Society’ (CNPS) Consent to Treatment: the Role of the Nurse (1994)\textsuperscript{314} and Consent for the Incapable Adult (2004)\textsuperscript{315} offer general instructions on the capacity to consent to treatment. The CNPS emphasized the legal presumption that all adults have the capacity to consent to treatment, and that this capacity varies from time and time and with the type of decision made.\textsuperscript{316} The CNPS recommended that obtaining consent to treatment should be considered a process rather than a single event.\textsuperscript{317} The CNPS also recommended that careful documentation is required when consent is obtained from a substitute decision maker.\textsuperscript{318}

The Canadian Medical Protective Association (CMPA) provided no specific direction that applies to the covert administration of medication. They offer a general discussion on the legal issues relevant to obtaining consent and substitute decision-making.\textsuperscript{319} The CMPA highlights the importance of consent and how without it, physicians may expose themselves to charges of negligence and fraud:

A physician may be liable when no consent is given at all or when the treatment went beyond or deviated significantly from that for which the consent was given. Allegations of assault and battery might also be made is consent to treatment was obtained through serious or fraudulent misrepresentation...\textsuperscript{320}

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\textsuperscript{315} CNPS (1994), supra note 314.
\textsuperscript{316} CNPS (1994), supra note 314 at 2.
\textsuperscript{317} CNPS (1994), supra note 314 at 2.
\textsuperscript{318} CNPS (1994), supra note 314 at 2.
\textsuperscript{320} CMPA (2006), supra note 319 at 6.
\end{flushleft}
In 1999, the Canadian Healthcare Association, the Canadian Medical Association, the Canadian Nurses Association and the Catholic Health Association of Canada prepared the Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care.\textsuperscript{321} The Joint Statement emphasized the “therapeutic relationship”\textsuperscript{322} as being centered on the informed choices of the person receiving care. Care recipients should be provided with necessary support (including time and information) in order to participate effectively in treatment decisions.\textsuperscript{323} The Joint Statement outlined key elements of conflict resolution processes for conflicts between HCPs and also between HCPs and persons receiving care. Conflicts should be resolved in as informal a manner as possible. Formal procedures should be considered only after informal procedures fail.

An arm’s length program of the Ministry of Health and Long-Term Care, the Psychiatric Patient Advocacy Office (PPAO) provides advocacy services to in-patients. The PPAO also engages in systemic advocacy and public education through the development of “InfoGuides”. The PPAO published an InfoGuide about Covert Medication in 2009.\textsuperscript{324} The PPAO defined covert medication as “the practice of hiding medication in food or beverages so that it will be undetected by the person receiving the medication.”\textsuperscript{325} Where a person is incapable of making a treatment decision, a substitute decision maker must consent to the use of covert medication.\textsuperscript{326} The PPAO argued that physicians and nurses might be professionally required to disclose the practice if directly asked about it.

\textsuperscript{321} Canadian Healthcare Association, Canadian Medical Association, Canadian Nurses Association & Catholic Health Association of Canada, Joint Statement on Preventing and Resolving Ethical Conflicts Involving HCPs and Persons Receiving Care (Ottawa: CMA 1999), online: CMA <policybase.cma.ca/dbtw-wpd/PolicyPDF/PD99-03.pdf> [Joint Statement].
\textsuperscript{322} Joint Statement (1999), supra note 321 at 2 “A good therapeutic relationship is founded on mutual trust and respect between providers and recipients of care. When care providers lose this sense of mutuality, they become mere experts and the human quality in the relationship is lost. When persons receiving care lose this sense of mutuality, they experience a perceived or real loss of control and increased vulnerability. Because persons receiving care are often weakened by their illness and may feel powerless in the health care environment, the primary responsibility for creating a trusting and respectful relationship rests with the care providers.”
\textsuperscript{323} Joint Statement (1999), supra note 321 at 2.
\textsuperscript{324} PPAO (2009), supra note 15.
\textsuperscript{325} PPAO (2009), supra note 15 at 1.
\textsuperscript{326} PPAO (2009), supra note 15 at 1.
A person may make a complaint to the College of Nurses of Ontario (CNO) or the College of Physicians and Surgeons of Ontario (CPSO) about the covert administration of medication. The covert administration of medication should be recorded in medical charts. The PPAO also outlined possible treatment issues with the covert administration of medication, including that a patient would be unable to advise the medical team about adverse reactions.

The United Kingdom, and Scotland in particular, has taken legislative and political effort to regulate the practice of the covert administration of medication. The efforts have focused on the covert administration to persons with mental health issues and older persons.

In 2004, UK’s Royal College of Psychiatrists issued the statement, *Covert Administration of Medicines*. The Statement provided that treatment should be made available to patients according to their best interests and administered in the least restrictive fashion. The College acknowledged that in “exceptional circumstances”, this might require the administration of medicines in food or drink, without the patient’s knowledge. Before administering medication covertly, psychiatrists must consult with pharmacists to ensure that the medication can be mixed with food or drink. Any treatment plan should be subject to weekly review in order to determine if the patient has regained capacity to make treatment decisions. The Royal College also required that all National Health Service (NHS) trusts develop a policy on the covert administration of

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327 PPAO (2009), *supra* note 15 at 2: “Given the exceptional nature of this practice, it is reasonable to assume that clinical staff would document its use.”
328 PPAO (2009), *supra* note 15 at 3-4.
330 Royal College of Psychiatrists United Kingdom, “College Statement on Covert Administration of Medicines” (2004) 28 Psychiatric Bull 38 [Royal College UK].
331 Royal College UK, *supra* note 330 at 2. See also the second use of the term “exceptional” at para 15.
medication. The Royal College also considered the application of the UK’s *Human Rights Act* (1998).

In 2013, the Mental Welfare Commission for Scotland updated its *Good Practice Guide: Covert Medication*, commenting on the practice for persons with mental health issues, including people with dementia, intellectual disability, mental illness or brain injury. It emphasized that medication should never be covertly administered if the patient is capable of making health care decisions. Staff must record when medication is covertly administered. Crushing tablets into food or drink may mean that the medication is given without its product license. The Mental Welfare Commission also reviewed the application of the *European Convention on Human Rights* (ECHR), the UK’s *Human Rights Act* (1998), the *Adults with Incapacity (Scotland) Act* (2000) and the *Mental Health (Care and Treatment) (Scotland) Act* (2003).

In 2012, the Nursing and Midwifery Council (NMC), the regulator of UK’s nurses and midwives, updated its position statement, *Covert Administration of Medicines*. The NMC supported the practice in certain circumstances, finding that the covert administration of medicines is “only likely to be necessary or appropriate in the case of patients or clients who actively refuse medication but who are judged not to have the capacity to understand the consequences of their refusal.” The NMC directed its

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332 Royal College UK, *supra* note 330 at para 16: “Trusts and organizations should develop a policy on this issue.”
334 Mental Welfare Commission, *supra* note 333 at 6: “This guidance applies only to situations in which an individual lacks capacity to make a decision regarding medical treatment and refuses treatment. Under human rights law, the right to respect for private life means that individuals capable of making the decision have the right to accept or refuse medical treatment, even where a refusal might lead to a fatal outcome. Covert medication must never be given to someone who is capable of deciding about medical treatment.”
335 Mental Welfare Commission, *supra* at 12.
members to “refer to local and national policies and apply the requirements of the law, particularly in relation to capacity.”\textsuperscript{337}

In 2006, the United Kingdom Psychiatric Pharmacy Group (UKPPG) adopted its policy: “The Administration of Medication in Food or Drink to People Unable to Give Consent to or Refuse Treatment Administered in this Way.”\textsuperscript{338} The UKPPG highlighted the lack of guidance that governs the covert administration of medication.\textsuperscript{339} The UKPPG distinguished between patients who “actively” refuse medication, patients who refuse because they find it difficult to swallow the size of the tablet and patients who refuse because they do not understand the consequences of refusal. Where a patient actively refuses medication – and for whom treatment is considered essential for their quality of life and health – the UKPPG “suggests” that medication cannot be administered in food. Instead, there must be multidisciplinary discussion of options include working with the patient and her family to try to get consent. The policy “prohibits the hiding of medication in food and drink” as the practice “could still be perceived as being deceitful and could be open to abuse.”

In 2009, the Maldivian Nurses Association and the World Health Organization prepared the \textit{National Medication Practice Standards}. These Standards permit the practice where the patient is incapable of making treatment decisions and in situations where the practice has been carefully considered.\textsuperscript{340}

\textsuperscript{337} NMC (2012), \textit{supra} note 336.

\textsuperscript{338} United Kingdom Psychiatric Pharmacy Group (UKPPG), \textit{The Administration of Medication in Food or Drink to People Unable to Give Consent to or Refuse Treatment Administered in this Way} (2006), online: UKPPG < www.ukppg.org.uk/tablets-in-food.html >. In 2010, the UKPPG merged with the College of Mental Health Pharmacists to form the College of Mental Health Pharmacy. The status of the UKPPG's older policy is unclear, though it appears not be in effect.

\textsuperscript{339} UKPPG, \textit{supra} note 338 at 1: “Although there is legal support under certain circumstances to prescribe medication to adults who mentally cannot consent to treatment there are no nationally agreed protocols or standards for the administration of such medication in food or drink.”

\textsuperscript{340} Maldivian Nurses Association and World Health Organization, \textit{National Medication Practice Standards} (2009) online: www.health.gov.mv/standards/9_National%20Medication%20Practice%20Standards.pdf at 16: “Covert administration of medicines: administering medicines to patient against his/ her knowledge by disguising a dosage form in some way so that the patient is unaware of the administration. A) For patients who actively refuse medicines considered essential for the patient's health and well-being but who do not have the mental capacity to understand the consequences of their refusal, covert
V. Summary

Few legal sources govern the covert administration of medication. However, Ontario legislation governs related issues including treatment with substitute consent and treatment without consent in emergency settings. Similarly, international legal materials are silent on the specific questions raised by covert medication. There is no caselaw which considers the legal impacts of the covert administration of medication, possibly due to the barriers to bringing a claim where neither the patient nor the SDM is aware of the fact of the concealment of medication in food or drink. The Superior Court in SMT v Abouelnaser rejected a challenge to the constitutionality of the use of physical restraints to effect treatment without explicit SDM consent. The Court’s decision in SMT v Abouelnaser might provide some support for the practice of covert medication if the concealment is properly characterized as part of a “plan of treatment” to effect routine treatment that is lawfully consented to by an SDM. Three professional organizations of nurses in Canada have commented on the practice. Otherwise, there is very little guidance available to health practitioners about the covert administration of medication.
CHAPTER 4: LITERATURE REVIEW

This chapter reviews the literature relevant to the covert administration of medication to adult inpatients in psychiatric settings in Ontario. The “covert administration of medication” is defined here as concealment of medication in food or drink so that it will be consumed undetected. While the focus will be on the application of practice in Ontario, this literature review also considers the practice outside of Ontario and also considers the related practices of the deceptive use of placebos.

This literature review considers the administration of medication to i) treat mental health issues, ii) treat other health issues or iii) manage challenging behaviour of treatment non-adherent patients. The bulk of the reviewed literature focuses on the covert administration of medication by HCPs; however, family members or other caregivers may also covertly administer medication.341 The focus is on the administration of medication to persons who are determined to be incapable of consenting to treatment.342 The bulk of the literature reviewed focuses on the practice of the covert administration of medication to (i) patients in psychiatric facilities (including psychiatric units in general hospitals), as well as (ii) to older persons living in long-term care settings. While this study focuses on the practice within the psychiatric system, the literature review draws on the scholarship about its practice in the long-term care setting. Indeed, the bulk of the available literature considers its practice in long-term care settings.

This chapter reviews scholarship relevant to the covert administration of medication in psychiatric and long-term care facilities. This section includes editorials, commentary,

341 For more detail on the practice of the covert administration by family members, see Stroup, Swartz & Appelbaum (2002) supra note 17. See also Wong, Poon & Hui (2005) supra note 18. See also Srinivasan & Thara (2002), supra note 25.
342 The covert administration of medication to a person who is in fact capable of consent to that treatment is a clear violation of the provisions of HCCA, supra note 194.
secondary analyses of population health data, qualitative analyses and chart reviews. The selection of research is not limited to the Canadian context. Rather, research is gathered from India, Norway, the United States and the United Kingdom.

I. SEARCH STRATEGY

The following five electronic search engines were relied upon: Quicklaw (Lexis-Nexis), HeinOnline, Medline (OVID), PsychInfo (OVID), Cochrane Database and CANlii. Each search relied on various combinations of the following search terms: “covert medication”, “concealed medication”, “chemical restraints”, “battery”, “covert administration of medication”, “surreptitious medication”, “medication by subterfuge”, “deceptive use of placebo” and “placebo medication.” Truncated forms of the key words were used where possible.

The broadest inclusion criteria were used in order to cast the widest net. No date or language limits for the searches were set. Similarly, few exclusion criteria were employed. Material about the covert administration of medication to children was not included. Material about “covert non-compliance” by patients in psychiatric institutions was not included. The full text of relevant references was obtained. Non-English language papers were excluded. The selection of research is not limited to the Canadian context. Rather, research is gathered from a variety of geographic regions, including India, Norway, the United States and the United Kingdom.

This search strategy did not retrieve all of the publications relevant to the focused questions. In particular, it missed some shorter commentaries and opinion pieces on the topic. To address this absence, further citations were identified through the examination of other publications’ reference lists. Bibliographies of eligible articles were checked for possible references. The titles and abstracts of identified references were screened.

The results of the literature review are included in Table 1.
II. Reviews (Most Relevant First)

McCullough, Coverdale and Chervenak (2007) systematically reviewed the literature on the ethical implications of covert administration of medication to persons with mental health issues. The authors concluded that the practice is ethically justified for patients with seriously impaired decisional autonomy who physically resist medications and clinically deteriorate as a result.343 The authors selected the practice of “concealed medication” as an example of argument-based normative ethics. The authors only identified seven papers, although none of them met the standards of argument based clinical ethics.

In 2010, Haw and Stubbs systematically reviewed the “relatively sparse” literature on the covert administration of medication to older adults.344 The authors pointed out that little has been published about “what actually goes on in practice” 345 including about the types of medication that are covertly administered.346 Legal frameworks, including the application of the European Convention on Human Rights (ECHR), were described. The covert administration of medication to sedate a patient “could be construed as chemical restraint.”347 The authors concluded that while the practice is “common” in nursing homes, it is often undocumented.348 Data were only extracted from eight studies and one inspection report.

343 McCullough, Coverdale & Chervenak, supra note 7 at 74.
344 Camilla Haw & Jean Stubbs, “Covert Administration of Medication to Older Adults: A Review of the Literature and Published Studies” (2010) 17:9 J Psychiatr Mental Health Nurs 761.
345 Haw & Stubbs (2010), supra note 344 at 2.
348 Haw & Stubbs (2010), supra note 344 at 6.
III. EMPIRICAL STUDIES (CHRONOLOGICAL)

Haw and Stubbs (2010) surveyed the charts of 110 inpatients at a psychiatric inpatient setting in the UK and followed up with nurse and physician interviews. Nurses reported that 6 of 110 patients had received medication covertly; while, the psychiatrists reported that 10 patients had received medication covertly. Upon review of the charts, thirteen (11.8%) patients had received medication covertly. The most common medications covertly administered were antipsychotics, anxiolytics and hypnotics. All 13 of the patients who had received medication covertly were involuntarily hospitalized. The practice of covert medication was only recorded in the chart about half of the time. This study, however, may be limited in its generalizability, given that it was conducted at a specialist inpatient setting.

In 2009, the Care Commission and Mental Welfare Commission conducted inspection visits to 30 homes for the elderly in Scotland. The charts of 1335 residents were reviewed. They reported that 1.5% of the patients were receiving medication covertly in food or drink. During interviews, few staff were aware of legal requirements governing the covert administration of medication, including documentation requirements. The Care Commission and Mental Welfare raised concerns about the homes’ record-keeping practice, suggesting that the results may underestimate the practice’s prevalence.

In an observational study of medication administration on two long-stay wards for older mentally ill inpatients, Stubbs, Haw and Dickens (2008) reported that tablet crushing and capsule opening was common. In 4.5% of the incidents, the dose-modification was expressly contra-indicated by the manufacturer. It was not recorded how many doses

350 Haw & Stubbs (2010a), supra note 349 at 413.
were administered covertly, but in 50% of the instances where medication was crushed, it was because the patient regularly spat out or refused medication.\(^\text{353}\) The study had a small sample size, limiting the conclusions that can be drawn from it.

Barnes and others (2006) interviewed 11 registered nurses in 10 residential homes for older people in South Australia about their experience altering medication dose forms prior to administration of medicines.\(^\text{354}\) Nurses expressed that they felt it was “imperative” to administer prescribed medication even if that meant hiding medication in food and drink.\(^\text{355}\) Though not focusing on the covert administration of medication, nurses reported that they were given little coherent guidance to inform their decisions.\(^\text{356}\) This study may be limited in its generalizability to Ontario psychiatric settings.

Kirkevold and Engedal (2005) reported that the covert administration of drugs is common in Norwegian nursing homes.\(^\text{357}\) They estimated that 11% of residents in regular nursing homes and 17% in special care units for persons with dementia received medication covertly at least once in the past seven days. Routines for such practice were arbitrary, and the practice was poorly documented in patient records. Level of dementia, aggression and low function in activities of daily living were most predictive of the practice. In a follow-up study, Kirkevold and Engedal (2009) reported that the practice of covert medication might still be a problem in Norwegian nursing homes.\(^\text{358}\) About 14% of patients in Special Care units, and 9.6% of patients in residential units received medication without their knowledge. This study may be limited by self report or recall

\(\text{353}\) Stubbs, Haw & Dickens (2008), supra note 20 at 622.
\(\text{355}\) Barnes et al (2006), supra note 354 at 195: “With some residents, you've got to be little bit crafty about crushing medication, especially your dementia ones, and you need to [...] disguise it.”
\(\text{356}\) Barnes et al (2006), supra note 354 at 196: “In effect, they were often left to manage in an ad hoc fashion and, for many, this was a matter for concern.”
biases, given that nurses were asked to report whether medication had been hidden within the last seven days.

Macdonald and Woods (2005) interviewed 158 nursing staff in UK nursing homes about their attitudes towards caring for patients with dementia. About 54% of nurses reported the use of covert administration. In an earlier study, 445 residents from 157 nursing homes in South East England were interviewed. About 4% of residents had received medication covertly in the nursing home. About half of the time, medication meant to target mental health issues was covertly administered. About 43% of homes reported that they at least sometimes relied on covert medication. The results may not be generalizable since nurses were not randomly selected.

Wright (2002) conducted a cross-sectional survey of 763 nurses working in nursing homes in the UK. Of the 540 questionnaires completed, hiding medication in food was reported by 56.5% of the respondents. The author warns that nurses who choose to administer medication via a non-licensed method, including covertly, “should ensure that all other avenues have been considered and appropriate advice sought.” The study may be limited by selection bias, given that the study population was limited to only those nurses who chose to participate.

Srinivasan and Thara (2002) reported that the covert administration of medication is a common practice among outpatients in an urban outpatient setting in India. Family members of adults with schizophrenia were surveyed about their experience in the past year. About 58% of patients had a history of noncompliance. About half of the non-complaint patients were given medication by family members, under the psychiatrist's

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362 Srinivasan & Thara (2002), supra note 341.
advice, at least once without their knowledge. Gender, marital status, education or employment status did not predict its practice. The authors commented on the role of the family in India in regards to caring for persons with mental health issues. The retrospective nature of the study may lead to recall bias.

In a review of clinical charts, Treloar, Beats and Philpot (2000) found that medication was administered covertly at 71% of residential, nursing and inpatient units for people with dementia, in Southeast England. About 96% of staff interviewed thought that the practice was sometimes justified. About 94% of staff thought that a doctor should ask the opinion of caregivers before hiding medication in food or drink. Additionally, the practice was often not recorded because staff were concerned about disciplinary measures. The results may be skewed by self-report bias since the researchers relied on institutions to report on the practice.

In a self-report survey of psychiatric consultants in the UK, Pereira, Beer and Paton (1999) reported that one out of 39 responding psychiatric consultants admitted to adding oral medication to a patient’s drink without the patient’s knowledge. The study had a very small sample size, limiting the conclusions to be drawn from it.

IV. CASE COMMENTARY (CHRONOLOGICAL)

Pickering (2013) commented on the case of the covert administration of medication to a young Singaporean man, raising questions about the practice in low income countries, where access to mental health services are limited.

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363 Srinivasan & Thara (2002), supra note 362 at 535: “In many nations of the developing world, where economic needs often assume priority and are critical for day to day living, it can be expected that family management of non-compliance will continue as a viable solution for the acutely disturbed patient and the family.”


So, though the practice may still be frowned upon, at least on some level, the practical realities of attempting to care for a psychotic individual in the family home without any easily available professional support perhaps make covert medication a lesser evil.\footnote{Pickering (2013), \textit{supra} note 366 at 201.}

Lewin, Montauk, Shalit and Nobay (2006) reported on the case of a young man reporting to an emergency room with mental health issues. The authors outlined competing ethical, therapeutic and legal issues. Fear of professional censure inhibits open discussion about the topic. There is no specific case law on the point in the US nor is there specific guidance from the American Medical Association, American Psychiatric Association or the American Association of Emergency Psychiatry. The authors argue that it could be acceptable to covertly medicate a potentially violent patient in order to maintain overall safety of others in the ED.

Wong, Poon and Hui (2005) described a case of a young man with schizophrenia whose mother had been covertly administering antipsychotic medication in his soup.\footnote{Wong, Poon & Hui (2005), \textit{supra} note 18.} The authors raised the question of whether the doctor should continue to provide a prescription, thus allowing the covert medication to continue. The authors concluded that the justification of the practice depends on case-specific balancing of the respect for autonomy and the principles of beneficence/non-maleficence. In particular, the authors examine arguments that anti-psychotics can actually serve to restore autonomy.

Kellett (1996) reviewed an U.K. employment case of a nurse in a day hospital who was reprimanded for carrying out the orders of a physician to hide a tranquilizer in a patient's tea.\footnote{John M Kellett, \textquotedblleft A Nurse is Suspended: The Case\textquotedblright{} (1996) 313 BMJ 1249.} The physician was found not guilty of professional misconduct. The authors criticized the fact that the nurse was reprimanded while the physician escaped
liability. Accompanying commentary (such as Griffin and Bell, 1996) heartily supported the practice of covert medication.

V. OTHER COMMENTARY, INCLUDING NEWS REPORTS

There is emergent interest in the legal and ethical issues raised by the covert administration of medication. A recent issue of the *Indian Journal of Psychiatry* was devoted to the covert administration of medication. In its headlining article, Rao and others (2012) argued that while covert medication “appears intuitively improper...there may be merits in covert medication as an approach by a troubled family to re-establish homeostasis”, especially given the lack of community-based mental health services and supports in India.

Some commentators have raised concerns about the practice’s lack of transparency. Singh (2008) blamed the “veil of secrecy” for forcing the practice underground. Welsh and Deahl (2002) reported that fears of professional censure hide the practice from public debate. In an editorial piece, Treloar, Philpot and Beats (2001) argued that the most worrisome aspects of the practice of covert medication are its lack of openness and the poor documentation of the practice. According to Honkanen (2001), covert medication will continue “in secrecy and shame” without open debate.

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374 Welsh & Deahl (2002), *supra* note 14 at 126: “We must ensure that the sanctioning of such activities in certain prescribed situations does not herald a return to the dark ages of psychiatry, notwithstanding the defence of beneficent purpose.”
375 Adrian Treloar, Michael Philpot & Barbara Beats, "Concealing Medication in Patients' Food" (2001) 6 Lancet 62.
376 Honkanen (2001) *supra* note 16 at 229: “Without policies, awareness, and frank discussion of “underground” practices, surreptitious administration of medication will continue in secrecy and shame."
Despite the controversy raised by the practice, most commentators agree that medication should never be delivered covertly to people who are capable of making decisions about their treatment.\textsuperscript{377} Hung and others (2012) found that they could "see no ethics-based justification for covert medication in a non-emergent situation or if the patient has the capacity to make decisions."\textsuperscript{378} In his commentary, Levin (2005) found that, in the US, the covert administration of medication to a person who is capable of making treatment decisions is illegal.\textsuperscript{379}

Critics challenge the practice's limitations of patients' autonomy. Some condemn the covert administration of medication as overly paternalistic. In an editorial, Honkanen (2001) argued that the covert administration of medication is rarely ethically justified. Covert medication is a breach of the physician's duty to respect the patient's autonomy and is an “unethical shortcut”.\textsuperscript{380} Ahern and Van Tosh (2005) also took a strong position against the practice of surreptitious prescribing, describing it as “coercive and forced treatment at its most sinister.”\textsuperscript{381}

Others argue that the practice may be acceptable in certain limited situations if patients are incapable of making treatment decisions and are treatment incompliant. For instance, while Whitty and Devitt (2005) did not take a strong position, they found that the practice might be justifiable where an interdisciplinary team of care providers makes the decision to covertly medicate.\textsuperscript{382} Lamnari (2001) remarked that the practice is ethical if physicians “remain sensitive and respectful” and “act truly with their best

\textsuperscript{377} See for example Catherine Jenkins & Alisa McKay, “Collaborative Health Promotion in Middle and Later stages of Dementia” (2013) 27:37 Nursing Standard 49. See, however, Latha (2010) supra note 142 at 116: “...the position is more difficult if a patient has capacity.”

\textsuperscript{378} Hung, McNiel & Binder (2012), supra note 24 at 244: “In the emergent, nonautonomous situation, before considering covert administration of medications in an emergency, clinicians should attempt reasonable measures of persuasion or show of force.”

\textsuperscript{379} Levin (2005), supra note 21.

\textsuperscript{380} Honkanen (2001) supra note 16.

\textsuperscript{381} Ahern & Van Tosh (2005) supra note 16.

\textsuperscript{382} Whitty & Devitt, supra note 17.
interests at heart.”

Hung and others (2012) pointed out that UK legislators have “acknowledged that for an incapacitated individual, repeated restraint and injection of treatment may be more degrading and inhumane than the covert administration of medication.”

However, in a special issue of the *Indian Journal of Psychiatry*, Anthony (2012) argued that covert medication is “a less acceptable option” than forced medication.

Some commentators have raised slippery slope arguments. Lynn and Rios (2006) argued that the covert administration of medication in emergency departments sets a dangerous precedent. They pointed out “one could argue that it would be safer if every psychiatric patient were covertly pre-medicated upon entering the [emergency department].” A recent *National Post* article quoted Dr. Christy Simpson, head of Dalhousie University’s bioethics department: “If I as a family member found out that medication was being given this way. [...] I would start raising questions about ‘Well, what else are you doing?’”

Scott and Williams (1997) raised similar questions about the practice’s use of deception, describing covert mediation as “the thin end of the wedge and gives rise to abuse.”

Some have examined the legal issues raised by the covert administration of medication. Davidson (2008) argued that in “almost all circumstances” covert medication is unlawful.

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383 Anna M Lamnari, “Point-Counterpoint: Is it Ethical to Give Drugs to People with Dementia? Yes: It Is Ethical if it is in Their Best Interests” (2001) 174 Western J Med 228.
384 Hung, McNiel & Binder (2012), *supra* note 24 at 242: “The legislators acknowledged that for an incapacitated individual, repeated restraint and injection of treatment may be more degrading and inhumane than the covert administration of medication.”
386 Lynn & Rios (2008), *supra* note 16 at 478: “If covert administration is allowed this could lead to more commonplace violations.”
388 Blackwell (2013), *supra* note 94.
and can amount to battery.\textsuperscript{390} Hung and others (2012) found that no court has ruled on the covert administration of medication in the United States. Nevertheless, they characterize inappropriate use of medications “not only as mistreatment and malpractice but, also, in the most egregious cases, as criminal battery.”\textsuperscript{391} Sarin (2012) remarked that Kala’s (2010) position that covert medication can be defended as “acting in good faith” remains untested by Courts. He argued that it is just as likely that covert medication would be construed as assault or battery.\textsuperscript{392} Whitty and Devitt (2005) argued that clinicians who covertly medicate are “taking the law into their own hands.”\textsuperscript{393}

Scholarship has also raised the clinical implications of the practice of covert medication. Noroian (2005) pointed out that a person who has been covertly medicated cannot report on the medication’s side effects.\textsuperscript{394} HCPs must rely on less reliable sources of information regarding the effectiveness of the medication. Levin (2005) considered the clinical implications of the practice’s use of deception: “Force and trickery only reinforce the sense of loss of control that mental patients often feel.”\textsuperscript{395} According to Whitty and Devitt (2005), covert medication may also deny a patient the “opportunity of gaining insight.”\textsuperscript{396} Stroup, Swartz and Appelbaum (2002) highlighted concerns that the practice may result in poorly supervised use of medication, making it difficult for family members to persuade patients to go to the clinic for periodic monitoring and blood work.\textsuperscript{397}

\textsuperscript{390}Laura Davidson, “Covert Medication” (2008) 158 NJ 1066
\textsuperscript{391} Hung, McNiel & Binder (2012), supra note 24 at 241: “The practice of covert medication discussed in the literature raises the question of whether patients have brought legal action against practitioners for this conduct. However, a search of LexisNexis identified no U.S. legal cases to date that contain rulings on the covert administration of medication. Nonetheless, the inappropriate use of medications can be viewed, not only as mistreatment and malpractice, but also, in the most egregious cases, as criminal battery. Despite the lack of U.S. legal rulings on covert medication, there is a long case history in the United States in two relevant areas: informed consent and the right to refuse treatment.”
\textsuperscript{392} Alok Sarin, “On Covert Medication: The Issues Involved” (2012) 54 Indian J Psychiatry 271: “While, as Kala (2010) points out, this can be considered as acting in good faith, the strength of that defense is yet to be tested in Court, and it is equally likely that the judicial system would construe this as assault or battery, providing grounds for criminal liability.”
\textsuperscript{393} Whitty & Devitt, supra note 17 at 482.
\textsuperscript{394} Noroian (2005), supra note 19.
\textsuperscript{395} Levin (2005), supra note 21.
\textsuperscript{396} Whitty & Devitt, supra note 17.
\textsuperscript{397} Stroup, Swartz & Appelbaum, supra note 17.
Instead, the authors recommend that psychiatrists work with families to develop non-coercive alternatives.

Resource limitations may drive the decision to covertly medicate. Levin (2005) raised concerns that covert administration may be used to avoid treatment delays. Kala (2012) pointed out that covert medication is “used fairly commonly” and argues that legislation must regulate when it may be used as well as prescribe safeguards. While it “should probably be used a little less commonly”, until community mental health services are in place, covert medication should be “mainstreamed”. Whitty and Devitt (2005) were clear that covert medication should not be used to manage staff shortages.

Commentators have raised the application of advance directives. In Ontario, capable persons may name a person to make decisions about their personal care when they become unable to make those decisions. A capable person may also give their attorney instructions about the kind of care they want. Hung and others (2012) argued that if a health team decides to covertly medicate then psychiatric advance directives should be taken into account. Whitty and Devitt (2005) reported that the use of advance directives avoids the necessity of surreptitious prescription. Singh (2008) offered an example of an advance directive that sanctions the use of covert medication. Latha (2010) argued that stable patients with insight should be encouraged to prepare an

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398 Levin (2005), supra note 21.
400 Whitty & Devitt, supra note 17 at 483.
401 HCCA, supra note 194 at s 5: “5. (1) A person may, while capable, express wishes with respect to treatment, admission to a care facility or a personal assistance service. 2) Wishes may be expressed in a power of attorney, in a form prescribed by the regulations, in any other written form, orally or in any other manner.
402 Hung, McNiel & Binder (2012), supra note 24 at 244: “What would happen if a patient indicated in a Psychiatric Advance Directive (PAD) that during a period of incapacity in an emergency he would prefer being covertly medicated to being physically restrained and given forced medication?”
403 Whitty & Devitt, supra note 17 at 482-3: “In such cases, advance directives may help with the decision process, because the patient could conceivably give informed consent to the clinician at a time when he or she is deemed mentally competent, and the clinician could proceed with surreptitious prescribing when the patient is considered to lack competence.”
advance directive specifically addressing such situations.\textsuperscript{404} However, Kala (2012) raised concerns about their potential misuse by a relative who has a “vested interest in a patient’s non-treatment.”\textsuperscript{405} Stroup and others (2002) argued that advance directives “may offer a solution” since a capable person could specify her desire for medicines without any indication of how the medicine should be given.\textsuperscript{406} Treloar, Philpot and Beats (2001) outlined possible safeguards, including the use of advance directives, but argued that advance directives may not work for concealed medicines because they require that people consent in advance to be deceived.\textsuperscript{407}

Particular issues arise in the case of covertly medicating patients with dementia. In his letter to the editor, Noroian (2005) remarked that the ethical issues raised by the practice are different for persons with long-term mental incapacity (including persons with dementia, elderly persons or persons with intellectual disabilities) than for persons with temporary or fluctuating mental incapacity - including persons with some type of mental health issue. It may be that it is easier to justify the practice for a person with long-term incapacity than for a person with fluctuating incapacity.\textsuperscript{408} Jenkins and McKay (2013) considered the possibilities of partnerships between nurses and pharmacists to promote “effective person-centered care” to support patients with dementia.\textsuperscript{409} They emphasize that every effort should be made to give medication openly to patients with

\textsuperscript{404} Latha (2010), supra note 142 at 118. See commentary about Szasz’s interpretation of the utility of advance directive at 112.  
\textsuperscript{405} Kala (2012), supra note 399 at 264.  
\textsuperscript{406} Stroup, Swartz & Appelbaum (2002) supra note 341 at 538: “A capable person could specify their desire for medicines without any indication of how they would be given. Concealed medicines would then be an option that avoids force and is consistent with the advance directive’s instructions.”  
\textsuperscript{407} Treloar, Philpot & Beats (2001) supra note 375 at 63: “Advance directives may perhaps help provide some indication as to a patient’s views on covert medication. However, few of those making out an advance directive will have enough understanding of the potential problems that might arise. Most advance directives are written to preclude treatment, covert or otherwise. However, an advance directive that resulted in substantial harm to the patient would have to be challenged and rebutted before necessary treatment could be given. [citation] If this rebuttal may, strangely, increase the power of attorneys to require such practices, and would therefore need stringent safeguards to ensure that the attorney acts purely for the benefit of the patient. The protracted timescale, involving the use of these instruments, and the lack of apparent safeguards in current proposals, may mean that the use of common law remains the best, most flexible, and most transparent means of managing these problems.”  
\textsuperscript{408} Noroian (2005), supra note 19.  
\textsuperscript{409} Jenkins & McKay (2013), supra note 377.
dementia. Pharmacists can advise on suitable food with which medication can be mixed.\textsuperscript{410} Kyle (2012) points out that patients with dementia “often refuse to take their medication by clamping their mouth shut or spitting out tablets once the medication is in their mouth.” Nurses must consider “whether the harm caused by giving medication covertly is greater than not giving the medication at all.”\textsuperscript{411}

HCPs, and in particular nurses, may be anxious about discipline following the covert administration of medication. Ryan (2001) argued that there must be additional professional guidance available to nurses, including the need to discuss the ethical implications of particular cases.\textsuperscript{412} In a 2001 comment in the \textit{Nursing Times}, the author argued that a clearer policy statement on covert medication is required. A nurse who spends time with a client, offering explanation and reassurance, will likely have to deal less with the issue of covert medication.

By refusing to take their medication, patients are harming no one but themselves. But nurses who secretly administer drugs are harming the profession.\textsuperscript{413}

There is almost no commentary from patients or ex-patients whose medication has been covertly administered. Srinivasan (2012) shared his experiences as a person to whom medication was administered surreptitiously by his family: “When the news was finally broken to me one day, I felt an immense sense of relief rather than the expected anger.”\textsuperscript{414} He continued to state that covert medication, “though a human rights abuse, paradoxically leads to a greater quantum of protection of human rights...”\textsuperscript{415} Hung and others (2012) also argued, since there should be open and ongoing communications

\begin{flushleft}
\textsuperscript{410} Jenkins & McKay (2013), \textit{supra} note 377. \\
\textsuperscript{411} Gaye Kyle, “Medication Management in Older People With Dementia” (2012) 26:1 Journal of Community Nursing 31. \\
\textsuperscript{412} “UKCC ’not willing’ to justify hidden drugs”, \textit{Nursing Times} 97:36 (6 September 2001) 4. \\
\textsuperscript{413} “Nurses need a clear line from their employers on covert medication”, \textit{Nursing Times} 97:4 (25 January 2001) 3. \\
\textsuperscript{414} Tilak Srinivasan, “The Unknown User: Covert Medication: My User Experience” (2012) 54:3 Indian J Psychiatry 278 at 278: “My parents had no choice but to subject me to covert medication to prevent a relapse/breakdown.” \\
\textsuperscript{415} Srinivasan (2012), \textit{supra} note 414 at 279.
\end{flushleft}
between patients and HCPs, it may be appropriate to inform the patient of the fact of the covert administration of medication once she is stabilized. In her letter to the editor, Hartshorn (2013) argued that covert medication permits patient to “save face” when advised of its fact later.

People are often placed in a no-win position when confronted with the choice of taking unwanted medication and of having to refuse it in the interests of appearing autonomous and being the master of their own fate.

Editorial commentary surrounding the practice of covert medication is divided. The positions taken vary widely. Critics challenge the limitations of patient autonomy. Generally, some commentators characterize the covert administration of medication as overly paternalistic and unethical. Others suggest that the practice may be acceptable in certain limited situations if patients are incapable of making treatment decisions and are treatment incompliant. HCPs and family members may justify the practice as a way to improve the care of persons with mental health issues.

VI. THE DECEPTIVE USE OF PLACEBO MEDICATION: SELECTED RESEARCH

This section reviews selected scholarship relevant to the deceptive use of placebo medication in clinical settings. Additional scholarship, beyond the scope of this review, about the use of placebos in research, including sham surgery, exists. There is little

416 Hung, McNiel & Binder (2012), supra note 24 at 244.
417 Mary Hartshorn “Letter to the Editor” (2013) 41:1 J Am Acad Psychiatry Law 154 at 154: “My belief is that covert medication can often allow the individual to save face when apprised of its use later, at a time when he is more psychiatrically stable. It is then possible for the person to say that he was medicated without his awareness, and therefore, he is absolved from having caved in to the demands of others at a time when the illness was at the helm.”
418 Hartshorn (2013), supra note 417 at 154: “While I do not condone covertly medicating as a routine procedure, I do believe the dynamic account by Hung et al. explains why many people, upon learning of the incident, are only momentarily angry or actually may be grateful and receive the news calmly.”
419 See e.g. Honkanen (2001) supra note 16. See also Ahern & Van Tosh (2005) supra note 16. See also Lynn & Rios (2008), supra note 16.
420 Whitty & Devitt, supra note 17. See also Stroup, Swartz & Appelbaum (2002) supra note 17.
data about the extent of the deceptive use of placebos in clinical practice. There are additional questions about, where a placebo has been administered deceptively, whether the patient provided negatively informed consent to the possibility that the physician may administer a placebo during treatment without notice. Where an HCP does not secure negatively informed consent, the deceptive use of placebo medication is analogous to the covert administration of medication since it involves the intentional deception of a patient for a therapeutic purpose. The arguments for and against the deceptive use of placebos mirror those used to support or reject the covert administration of medication.

A placebo is an inert substance believed to have no specific clinical effect. The “placebo effect” is the change to a patient’s condition as a result of the placebo’s administration. Barnhill (2011) defined deceptive placebo use: “when through words or actions, a physician knowingly causes a patient to believe she’s receiving a drug or treatment that has a specific pharmacological or physiological effect on her condition, when in fact she’s receiving a placebo.” Like covert medication, the use of placebo for therapeutic purposes is controversial, though reportedly common.

423 For a recent example of the use of placebos in research, including their administration in food and drink, see Vikram Reddy & R Harsha, “Ethical and Legal Aspects of Conducting Clinical Trials in Alcohol Withdrawal Syndrome” (2014) 8:5 J Clin Diagn Res HE01.
427 Margit Fässler, Karin Meissner, Antonius Schneider & Klaus Linde, “Frequency and Circumstances of Placebo Use in Clinical Practice - A Systematic Review of Empirical Studies” (2010) 8:1 BMC Medicine: “The proportion of respondents reporting that they had applied ‘pure’ placebos (for example, saline injection) during their professional life varied between 17% and 80% among physicians and between 51% and 100% among nurses, but it seems that the actual frequency of such use seems to be rare. The use of ‘impure’ or ‘active’ placebos (for example, antibiotics for viral infections) is likely to be much more frequent.”
Proponents of the deceptive use of placebos assert that deception is necessary for the placebo to be effective. The placebo effect cannot be obtained if the patient is aware that a placebo will be, or has been, administered. Kolber (2007) defended deceptive placebo use, claiming that its use should not be categorically prohibited. He argued that placebos should be applied sparingly because patients may become aware of the practice of placebo deception, which, in turn, may reduce its therapeutic value. Foddy (2009) argued that while deception is normally objectionable, the deceptive use of placebos could be ethical. Fried and Perlis (2012) contended that misleading patients “may - at times - paradoxically actually further a patient’s autonomy” if, for example, the patient is upset and, consequently, makes a decision inconsistent with her beliefs. These arguments are similar to those that support covert medication.

Critics challenge the impact of placebo administration on patient autonomy. Its use of deception impairs patients’ access to information that is necessary for informed consent to treatment. In their literature review, Asai and Kadooka (2013) concluded that the practice is unethical. Grace (2006) argued that the harm caused by the deception outweighs the good derived by the placebo effect, pointing to the impact on the trusting clinical relationship. She also argued that since the use of placebo medication is a failure to “respect their rights to make an informed decision”, it cannot be justified, even if the deception is not discovered.

The deceptive use of placebos raises legal questions similar to those raised by the covert administration of medication. The practice invokes potential claims against HCPs of

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428 Adam J Kolber, "A Limited Defense of Clinical Placebo Deception" (2007) 26:1 Yale L & Pol'y Rev 75 at 134: “Indeed, if the categorical prohibition on placebo use increases patient suffering by reducing patient options, its claim to the moral high ground appears increasingly deceptive.”


fraud, breach of duty to obtain informed consent and malpractice.\textsuperscript{434} In their 2011 \textit{Medication Guidelines}, the College of Registered Nurses of Nova Scotia (CRNNS) permits the administration of a placebo only if it “has been discussed with the client involved, informed consent has been acknowledged, and the client’s signature has been received and witnessed.”\textsuperscript{435} The CNRSS relies on the CNA’s \textit{Code of Ethics for Registered Nurses} (2008): “Administering placebos without a client’s knowledge or consent is an unacceptable practice that violates the clients trust and the \textit{Code of Ethics for Registered Nurses}.”\textsuperscript{436} The American Medical Association (2006) prohibits the deceptive use of placebos since the deception associated with placebo use conflicts with important values of patient autonomy and may undermine trust and negatively affect the physician-patient relationship. According to the AMA, “A placebo must not be given merely to mollify a difficult patient, because doing so serves the convenience of the physician more than it promotes the patient’s welfare.”\textsuperscript{437} The Canadian Medical Association has no guidelines on the use of placebos in clinical practice.

Critics raise additional concerns about the clinical implications of placebos since their use may mask and potentially delay other treatments. Kapp (1983) reported that the administration of placebos caused toxic reactions in 5% to 10% of patients.\textsuperscript{438} Some patients may experience adverse side effects from placebo use, described by Colloca and

\textsuperscript{435} College of Registered Nurses of Nova Scotia (2011), \textit{supra} note 312.
\textsuperscript{436} College of Registered Nurses of Nova Scotia (2011), \textit{supra} note 312 at 30.
\textsuperscript{438} Kapp (1983), \textit{supra} note 434 at 395: “A physician must exercise due care in ascertaining the probable effects of the drug or other treatment he or she prescribes and must observe appropriate precautions in its use. Thus, a malpractice suit may lie when a patient suffers a negative placebo reaction and the harm should have been reasonably foreseeable to a competent physician.”
Finniss (2012) as the “nocebo” effect.439 Aside from direct clinical impacts, the use of placebo medication may also undermine the physician-patient relationship.

Most commentators conclude that placebo practice may only be justifiable under strictly defined circumstances. Miller and Colloca (2009) proposed two “ethical requirements” for the use of placebos in clinical practice.440 First, there must be evidence of clinical benefit of a given placebo. Second, there must be evidence that the placebo’s effective use requires patient deception.

Some scholars have commented on deceptive use of placebos in psychiatric clinical settings. In their case comment, Bolton and others (2012) reported on the use of placebos to a patient determined to be incapable of making treatment decisions. They advocated that placebos should be more widely considered for patients who are determined to be incapable of making treatment decisions.441 Pointing to research that demonstrates that electroconvulsive therapy (ECT) is only marginally more effective than sham ECT, Blease (2013) argued that patients should be informed that ECT may only work as a placebo.442 She concluded, “failure to reflect the full current status of theories and medical knowledge in critical clinical encounters can be considered a deception.”443

V. SUMMARY

Research on the covert administration of medication has contributed to an understanding of the characteristics of the practice, mostly in long-term care settings.


443 Blease (2013), supra note 442 at 169.
Estimates of its prevalence on residents in nursing homes in Norway range from 10% to 20%.\textsuperscript{444} Most UK institutions report that the practice does occur.\textsuperscript{445} Staff and family caregivers generally respond positively to its practice.\textsuperscript{446} Nevertheless, institutions are not likely to have a policy to guide its practice.\textsuperscript{447} For the most part, scholarship has not considered the practice in psychiatric settings, and there has been no examination of the practice in Canada. In addition, the scholarship to date has not considered the practice’s underlying structures or the impact on patients’ rights experiences. This research complements this scholarship by addressing those gaps.

\textsuperscript{444} Kirkevold \& Engedal (2005), supra note 357. Kirkevold \& Engedal (2009), supra note 358.
\textsuperscript{445} Treloar, Beats \& Philpot (2000), supra note 364.
\textsuperscript{446} Treloar, Beats \& Philpot (2000), supra note 364; Macdonald \& Woods (2005) supra note 359; Srinivasan \& Thara (2002), supra note 341.
\textsuperscript{447} Treloar, Beats \& Philpot (2000), supra note 364.
### TABLE I: RESULTS OF THE LITERATURE REVIEW

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CHAPTER 5: METHODS AND METHODOLOGY

As set out in Chapter 1 ("Introduction"), this research considered the following questions:

1. What are the common themes of institutional policies, clinical protocols or practice guidelines that apply directly or indirectly to the covert administration of medication?
2. What is the understanding of (1) legal experts, including patient advocates and ex-patient advocates, (2) nurses with inpatient psychiatric nursing experience, and (3) and psychiatrists of the impact of covert administration to the rights-situation of incapable adult inpatients in psychiatric settings?
3. What are the socio-political-legal structures underlying the practice of covert administration of medication to adult inpatients in psychiatric settings?

This study relied on the multiple theoretical frameworks set out in Chapter 2 ("Theoretical Frameworks"), including rights-based approaches and critical understandings of the law as it applies to persons with mental health issues. Unlike the rest of the thesis, this chapter deliberately adopts first-person language, in order to acknowledge my own role in the construction of the data.

I. METHODOLOGY

This research relied on a contextualized exploratory approach with an iterative, retroductive and interpretive analysis. This approach served as a useful starting point in that no evidence exists about the covert administration of medication in Canada. Because the practice of covert medication is covert, the practice remains under-theorized, under-researched and under-litigated.

The characteristics of qualitative research were most able to get at the context and structures of covert medication. The research considered the practice holistically; this is
an important consideration, given the "messiness" and the "greyness" surrounding it. A qualitative approach "does justice to that complexity, and respects it in its own right."448 Numerous questions, including whether the concealment is explicitly recorded in medical charts, impair the practice’s transparency, making quantitative methods difficult, impracticable or impossible.

This research relied on critical qualitative methodologies such as those adopted by critical disability scholars. Mertens (2005) characterized critical social research as “transformative” and drew on a wide variety of approaches including critical disability theory.449 Critical methodologies aim to expose hidden power structures. They reject the positivistic notion that scientific inquiry should be value-free. This research considered multiple understandings of the practice as voiced by physicians, lawyers and nurses. Indeed, critical theories posit that socially constructed relations of power mediate the construction of knowledge and data. As such, research cannot be divorced from wider social processes nor from the personal characteristics of the researcher.450

II. Method

The research incorporated multiple data collection methods in an attempt to obtain a comprehensive picture of the practice. In adopting a socio-legal framework, data were gathered in two parts:

1. Document analysis of institutional policies and practice guidelines that govern the covert administration of medication.

2. Focus groups and individual interviews relying on a discussion of three clinical case scenarios of the covert administration of medication. Stakeholders included

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(1) legal experts including patient advocates and ex-patient advocates, (2) nurses with inpatient psychiatric nursing experience and (3) psychiatrists.

i) Document Review and Analysis

To address the first research question, a document review/analysis of covert administration guidelines of Ontario psychiatric facilities was undertaken. The review aimed to identify the common themes of institutional policies, clinical protocols or practice guidelines that apply directly or indirectly to the covert administration of medication.

Relevant documents were collected from all Ontario facilities designated under Schedule 1 of Ontario's Mental Health Act.\(^{451}\) As set out by Ontario's Mental Health Act, Schedule 1 facilities are required to provide psychiatric services, including on an inpatient basis.\(^{452}\) Appendix A includes a list of facilities that were contacted. Two settings were not contacted: Kingston Penitentiary's Regional Treatment Centre was recently closed and Ottawa's Children's Hospital of Eastern Ontario serves children. The focus of this research is adult inpatients in psychiatric settings.

To conduct the document review, informal requests, by email, were directed to Ontario's 74 Schedule I facilities. Each organization’s guidelines, policies and clinical protocols governing medication administration to people determined to be incapable of making treatment decisions were requested. Each organization’s Media/Communication, Patient Relations, Privacy or Records departments was contacted. In some cases, correspondence was forwarded to the appropriate department.

\(^{451}\) MHA, supra note 212.
\(^{452}\) MHA Regulations, supra note 187 at s 4(1). See also Ontario Ministry of Health and Long Term Care, Designated Psychiatric Facilities under the Mental Health Act (2012), online: MOHLTC <www.health.gov.on.ca/en/common/system/services/psych/designated.aspx >.
This informal approach was generally successful. If the informal request was unsuccessful, freedom of information (FOI) requests were made, relying on Ontario’s *Freedom of Information and Protection of Privacy Act* (FIPPA).453 A FIPPA request was made to access the Centre for Addiction and Mental Health (CAMH) policy. Chapter 6 (“Results”) offers additional detail about the results of those disclosure requests. Ultimately, responses were received from all facilities surveyed.

The document review was restricted to the collection of clinical protocols or practice guidelines. However, some institutional respondents offered informal feedback about the practice. Some respondents pointed out that while there was no explicit policy, medication was never administered covertly or, if it was, it was done so only in rare circumstances. Respondents’ unofficial communication was not included in any stage of the data analysis.

This review determined that only two psychiatric facilities in Ontario had a policy, guideline or protocol that explicitly governed the covert administration of medication. A thematic content analysis of the available documents was planned to identify the common items and protections available.454 This was, ultimately, determined to be impossible, given that only two policies were identified.

Background documents related to the development of these policies were also gathered through informal requests. Formal freedom of information requests were sent to both Ontario Shores Centre for Mental Health Sciences and Centre for Addiction and Mental Health (CAMH) for “background reports, memos, minutes of committee meetings and other related documentation.”

Focus Groups and Individual Interviews

Three semi-structured focus groups were conducted. Afterwards, three additional individual interviews were conducted to supplement the sample of nursing-participants [see below for additional detail about the recruitment of nurses]. Inclusion and exclusion criteria for each of sets of groups are included below.

A semi-structured interview [Appendix B] guided the moderation of the focus groups and individual interviews. This approach to interviewing allowed for some structure in presenting the topics/questions but also enabled flexibility in the participants’ responses. The initial topic guide was informed by the literature review and the research’s theoretical orientation. An open-ended question was included at the end of each focus group and individual interviews were arranged to probe for further detail.

The focus groups and individual interviews relied on three clinical case scenarios as examples of the covert administration of medication [Appendix C]. The scenarios were diverse and used a variety of patient characteristics (including diagnosis, race and age). As such, participants were encouraged to talk about fictional case scenarios, rather than disclose possibly controversial examples from their individual practices. To assist with the development of the scenarios, three psychiatric residents were recruited through my own professional networks. The psychiatric residents commented on early drafts of the three scenarios. One resident was interviewed in person. Another resident was interviewed by phone. Email feedback was received from a third psychiatric resident.

All participants were asked to provide written consent at the outset of the focus groups and interviews [Appendix D]. Participants were advised that they could opt out of the research at anytime. Consent letters emphasized the confidentiality of the participants’

responses. The consent letter also included a “confidentiality agreement”, which stated that participants agreed to not disclose information or views expressed by other focus group participants.

Trust and rapport were identified as being important to describing the practice of covert medication as accurately as possible. During the interviews and focus groups, I adopted a non-judgmental stance and used value free language as expressed in this sentence: “I’m interested in learning more about the practice.”

The three focus groups included the following participants: eight legal-participants in one group, five physician-participants in one group, and three nursing-participants in one focus group. Five to eight participants for each of the focus groups was proposed as an acceptable sample size to reach “data saturation” -- the point at which new information or new themes can no longer be gathered from the participants.457 Since only three nurses participated in the nurses’ focus group, three additional nursing participants were recruited for three individual interviews.

Focus groups and interviews were recorded using three separate devices (smart-phone, computer and digital recording device). I moderated the focus groups and conducted the interviews using a semi-structured guide (Appendix B) to facilitate the conversation. Written notes were taken during the focus groups and individual interviews. These notes supplemented the development of the transcripts.

Focus groups were determined to be an efficient way to get a variety of perspectives. They permit participants to “bounce ideas” off each other.458 Focus groups were

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457 Greg Guest, Arwen Bunce & Laura Johnson, “How Many Interviews Are Enough?: An Experiment with Data Saturation and Variability” (2006) 18 Field Methods 59 at 79: “For most research enterprises, however, in which the aim is to understand common perceptions and experiences among a group of relatively homogeneous individuals, twelve interviews should suffice.”

458 Richard A Krueger, Focus Groups: A Practical Guide for Applied Research, 2nd ed (London: Sage, 1994) at 6: “[A focus group is] a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, nonthreatening environment.” See also Sue Wilkinson, “Focus Groups in Feminist
composed of participants with shared characteristics.\textsuperscript{459} That is, each set of stakeholders was interviewed in separate focus groups. Concerns about using a focus group design were identified before data collection. There was a danger that dissenting voices would be left out, especially if there were power differentials between participants. To limit this problem, “cue cards” were available so that participants could ask anonymous questions or make anonymous comments. While no anonymous questions were received, participants did use the cue cards to share additional information. Also, confidentiality could not be guaranteed to focus group participants. The moderator could not control participant release of confidential information during the group interview. To minimize this risk, before the interview, participants signed a “confidentiality agreement” in the consent form [Appendix D].

I had originally planned to recruit participants who worked for professional associations, regulatory colleges and other organizations including, for example, the College of Nurses of Ontario (CNO), Canadian Medical Protective Association (CMPA) and the Ontario Psychiatric Association (OPA). Representatives of these organizations were to be invited to participate in one of four focus groups. However, early recruitment attempts were largely unsuccessful. As a result, the recruitment strategy was modified.

\textsuperscript{459} Pascale Lehoux, Blake Poland & Genevieve Daudelin, “Focus Group Research and The Patient’s View” (2006) 63 Soc Sci Med 2091 at 2093: “Focus group methodologists generally advocate seeking homogeneity in group composition (i.e., segmentation). Bringing together participants that share similar characteristics (e.g., age, gender, occupational status, ethnicity) is seen as a kind of social glue that adds fluidity and depth to discussions. Nevertheless, it is not entirely clear whether the researcher’s definition of homogeneity is compatible with that of the participants, and whether it actually facilitates social bonding and disclosure.”
Legal Experts including Patient Advocates and Ex-Patient Advocates

Eight legal experts participated in this focus group, held at a legal aid clinic in downtown Toronto. The inclusion criterion for this group was broad. Participants included lawyers representing persons with mental health issues, before the Consent and Capacity Board, as well as patient and ex-patient advocates. All except one of the participants was a lawyer. One of the legal-participants currently represented hospitals but had previously represented persons with mental health issues.

Participants were recruited using convenience sample methods. Potential participants were contacted through my professional and personal networks, including a list serve for lawyers who practice before Ontario’s Consent and Capacity Board. However, people were not directly invited to participate. I asked my contacts to forward a request for participation to their networks so that interested individuals connect with me directly.

Nurses with Recent Inpatient Psychiatric Nursing Experience

Nurse participants participated in either a focus group or an individual interview. Three nurses participated in one focus group. One of the participants worked in a hospital’s emergency department. Three additional individual interviews were held. The nurses’ focus group and individual interviews were held at the University of Toronto.

The inclusion criteria for nurse-participants are listed here:

- Nurses must have worked in an inpatient psychiatric setting in Ontario in the last two years.
- Nurses must have been members of the College of Nurses of Ontario (in order to consider the influence of professional obligations).
- Nurses must have been designated as registered practical nurses (RPNs) or registered nurses (RNs).
Nurse-participants for both the focus group and individual interviews were recruited in three ways. Nurses were not recruited through their place of work.

- through electronic correspondence sent to graduate students enrolled at the Bloomberg School of Nursing at the University of Toronto. I contacted students through the “Graduate Nursing Student Society (GNSS)”, not directly. The recruitment notice was posted on the GNSS Blackboard, GNSS website and sent by email on two different occasions;
- word of mouth (including relying on contacts through thesis committee); and
- snowball sampling (asking participants to forward the recruitment request to their contacts who might be interested).

Recruiting nurses proved somewhat difficult. I received some interest in response to the initial recruitment notice, but it was difficult to find a convenient meeting time for potential focus group participants.

*Psychiatrists*

The third focus group included five practicing psychiatrists at an inpatient unit at a Toronto hospital. The focus group was added to the agenda of a weekly regular meeting for unit psychiatrists. The inclusion criteria for psychiatrist-participants are outlined here:

- Physicians must have worked in an in-patient psychiatric setting in Ontario in the last two years.
- Physicians must have been members of the College of Physicians and Surgeons of Ontario, in order to consider the influence of professional obligations.

Physician-participants were identified through one of the following ways. Physicians were not recruited through their place of work but through the following means:
• through a point person at the University of Toronto’s Faculty of Medicine, Department of Psychiatry. The point person provided his colleagues with additional detail about the study, including how to contact me if interested;
• word of mouth (including relying on the contacts of members of the thesis committee); and
• snowball sampling (asking participants to forward the recruitment request to their contacts who might be interested).

I had anticipated difficulty scheduling a focus group for psychiatrists, given the pressures on their time. I was referred to a psychiatrist who acted as a “point person” and coordinated a meeting of five psychiatrists at the inpatient unit at the Centre for Addiction and Mental Health (College Site).

III. CODING AND ANALYSIS OF THE FOCUS GROUP/INTERVIEW DATA

This research relied on a critical approach to thematic content analysis. At each stage of analysis, I adopted an interpretive and reflexive stance, actively focusing on the practice’s context and relationships of power. This contextualized approach (with an interpretive analysis) borrowed from grounded theoretical principles. While the research did not adopt an explicit critical realist approach, it drew on Oliver’s (2012) approach to the adaptation of grounded theory to critical realist inquiry. Oliver described critical realism as able to marry “the positivist’s search for evidence of a reality external to human consciousness with the insistence that all meaning to be made of that reality is socially constructed.” Oliver’s adaptation of ground theory aligned

462 Oliver (2012), *supra* note 461 at 272: “It accepts that the social constructions themselves can constitute what we know as the reality of our social worlds. This makes it a useful approach for a field in which social workers must balance respect for individual meaning-making with evidence to test that meaning-making for its correspondence to an external reality.” She continued at 374 to address the value of acknowledging the presence of poverty, disability and violence: “Critical realism presupposes an objective reality which exists independently of our thoughts and whose discovery is one purpose of knowledge acquisition.”
well with the research purpose: to combine attention on the practice’s impact on “rights” and its underlying socio-political-legal structures.

Approximately five and half hours of recorded interview data were collected. Data analysis was undertaken using CAQDAS (Computer Assisted Qualitative Data Analysis Software). HyperRESEARCH was selected for its reputation and ease of use.

Data gathering and transcription and data analysis occurred concurrently. Marshall and Rossman (2011) proposed that there is no clear line between analysis and collection.\textsuperscript{463} Analysis was ongoing, a-linear, and included iterative movement between the data and the conceptualization, abstraction and interpretation. During data analysis, I reflected on and refined perceptions based on re-reading all transcribed materials. I prepared analytic memos, summarizing observations and interpretations and highlighting significant data.

Thematic analysis of the data involved a two-step coding process consisting of line-by-line coding (“descriptive data”) and focused coding (“categorizing”). First, drawing on grounded theory, each line of data from the transcripts was examined and initial codes developed. Concepts were generated from the data.\textsuperscript{464} Also drawing on grounded theory, a constant comparative method was used to compare data from different interviews.\textsuperscript{465} Additionally, I actively searched for negative cases, a strategy relevant to the grounded theory approach\textsuperscript{21}, by relying heavily on the preparation of coding and analytic memos.

By “flying low” to the data, emergent themes were constructed and re-constructed. Focused coding involved the comparison of frequent codes between transcripts, with the

\textsuperscript{463} Marshall & Rossman (2011), \textit{supra} note 170.

\textsuperscript{464} Barney Glaser, “Conceptualization: On Theory and Theorizing Using Grounded Theory” (2002) 1:2 Int J Qual Methods 1 at 2: “The researcher can use his or her own concepts generated from the data instead of using, and possibly forcing, the received concepts of others, especially those concepts of unduly respected theoretical capitalists.”

purpose of identifying theme codes.\textsuperscript{466} Drawing on grounded theory, data were made sense of by “confirming, refining, discarding and elaborating on themes, concepts or ideas...”\textsuperscript{467} Six categories of preliminary themes - and multiple subthemes – were developed after reading and re-reading the transcripts.

As concepts and themes were developed, I returned often to the research questions set out in Chapter 1 (“Introduction”) and the theoretical frameworks described in Chapter 2 (“Theoretical Frameworks”). I moved between these six preliminary themes, the research questions and the theoretical frameworks. Retroduction is a “central tool” of critical realist inquiry, which “mov[es] simultaneously between observations and theory, employing processes that were both inductive and deductive.”\textsuperscript{468} As proposed by Peter, Mohammed and Simmonds (2014), retroduction permits exploration of the interplay between individuals’ lives and their context.\textsuperscript{469}

Continuous attention to the research’s multiple theoretical underpinnings informed the realignment of themes. This research relied on rights-based approaches to consider the practice’s impact on the patients’ rights-experience. Three critical approaches to the law supported a fulsome consideration of the contexts and underpinnings of medication administration practice. As set out in Chapter 2 (“Theoretical Frameworks”), Critical Legal Studies aim to account for the power structures reflected in and replicated by the psychiatric system. New Legal Realism is concerned with the actual workings of the legal system, including its everyday “indeterminacy”. Critical Disability scholarship works to identify and interrogate complex power relationships inherent in how we understand concepts of autonomy, personal independence and interdependence. Despite their

\textsuperscript{467} Glaser & Strauss, supra note 465 at 138.
\textsuperscript{468} Oliver (2012) supra note 461 at 379.
\textsuperscript{469} Elizabeth Peter, Shan Mohammed & Anne Simmonds, “Sustaining Hope as a Moral Competency in the Context of Aggressive Care”, online: (14 October 2014) Nursing Ethics <nej.sagepub.com> at 4: “A critical approach demands an active interpretive stance on the part of the researcher in order to recognize power relations, roles and the inter-subjective structures within relationships... Retroduction allows the researcher to understand the interplay between individuals' lives and larger social and contextual forces.”
differences in focus, rights-based and critical legal approaches complement each other. By developing themes across and between frameworks, the gaps left by one framework were addressed by the other.

Relying on HyperRESEARCH, the relationships between the six preliminary themes (and sub-themes) were set out diagrammatically. After reflection and refinement, a typology of ten themes and multiple subthemes was developed. The themes and subthemes were organized according to the research’s purpose, as set out by the initial research questions (Chapter 1).

IV. ESTABLISHING THE TRUSTWORTHINESS OF THE DATA

Otherwise termed “soundness”, “authenticity” and “credibility”, Porter (2007) describes validity as “the extent to which research reflects accurately that to which it refers.”470 The conceptual edges of “validity” are disputed, as are approaches to its measurement.472 It is clear, though, that the appraisal of qualitative research methods differs from that of quantitative methods.473 Historically, concerns about the trustworthiness of qualitative data emerged from quantitative researchers’ emphasis on reliability, objectivity and generalizability.474 There are “longstanding tensions” about

470 John W Creswell & Dana L Miller, “Determining Validity in Qualitative Inquiry” (2000) 39:3 Theory Into Practice 124 at 124: “In these texts, readers are treated to a confusing array of terms for validity, including authenticity, goodness, verisimilitude, adequacy, trustworthiness, plausibility, validity, validation, and credibility.”
472 Porter (2007), supra note 471 at 85: “Different methodological approaches to qualitative research contain different approaches to validity, making it impossible to develop a universally accepted approach to the validation of qualitative research.
473 Joan M Eakin & Eric Mykhalovskiy, “Reframing the Evaluation of Qualitative Health Research: Reflections on a Review of Appraisal Guidelines in the Health Sciences” (2002) 9:2 J Eval Clinic Pract 87 at 187: “Qualitative research that is largely narrative, that relies fundamentally on language based data and whose relevance is not secured through a numerical calculus of ‘confidence intervals’, ‘P values’ and the like presents problems for the uninitiated reader. In response, a literature has developed around the question of how best to understand, evaluate and apply qualitative research in the health sciences.”
the assessment of validity of qualitative research, including resistance to checklists\textsuperscript{476} or other one-size-fits-all approaches. The literature includes various strategies to improve credibility and usefulness:

- Triangulation (using multiple sources of data for confirming specific findings);
- Member checking (reviewing of preliminary findings by participants);
- Peer debriefing (having someone familiar with the field review data and process);
- Inter-coder reliability (coding of data by multiple investigators);
- Audit trail (keeping records of all research steps taken);
- Searching for disconfirming evidence (looking for negative cases);
- Theoretical sufficiency (searching for data saturation).

This research relied on three strategies to improve its validity: pilot studies, negative case analysis and reflexive accounting. These three methods were selected for their efficiency in being incorporated into the research protocol. Relying on Elliot and Timulak (2005), validity was continually assessed throughout all stages of the research.\textsuperscript{477} Analysis was ongoing, a-linear, and involved iterative movement between the data and the conceptualization, abstraction and interpretation. I returned to assessment of the data’s goodness during all phases of the research.

\textsuperscript{476} Rosaline S Barbour, “Checklists for Improving Rigour in Qualitative Research: A Case of the Tail Wagging the Dog?” (2001) 322 BMJ 1115 at 1115: “Reducing qualitative research to a list of technical procedures (such as purposive sampling, grounded theory, multiple coding, triangulation, and respondent validation) is overly prescriptive and results in “the tail wagging the dog.””

i) Pilot Studies: Addressing Systematic and Random Errors

Before data collection began, two pilot studies were undertaken. The first was a project prepared for a graduate-level qualitative methods course at the Faculty of Nursing at the University of Toronto. The project was a preliminary inquiry into existent barriers to administering medication in psychiatric settings. Relying on purposive sampling strategies, two semi-structured interviews were conducted. One nurse worked in a pediatric psychiatric setting in Ontario. Another nurse worked in a general emergency setting in Quebec. Both interviews lasted about one hour.

Two additional semi-structured interviews were conducted with psychiatry residents at the University of Toronto. Both interviews were about 30 minutes (one in person and another on the phone). Written feedback was received from a third psychiatry resident. For these pilot interviews, three clinical case scenarios were drafted to illustrate examples of the covert administration of medication. I introduced the draft scenarios to the pilot study participants and ran through the draft semi-structured interview. I asked participants for feedback and to identify ambiguities in the clinical scenarios.

ii) Negative Case Analysis

Throughout all phases of the research, and especially during coding, analytic memos were prepared to summarize “key chunks of the findings” in order to “constantly evaluat[e] the plausibility of developing understandings.”478 During the development of those memos, I was attentive to possible disconfirming evidence. I aimed to consider conflicting and contradictory data. For instance, legal-participants raised the issue as to whether covert medication amounted to abuse or battery. Other participants considered

478 Marshall & Rossman (2011), supra note 170 at 220: “She is constantly searching through the data. She is constantly challenging the very explanation and interpretations that she is putting forward. We have used terms such as analytic inductions, constant comparative analysis and building grounded theory.... She is comparing her emerging themes and explanations with those in her literature review looking for any new variations and surprises.”
whether the failure to covertly medicate amounted to withholding medication, suggesting that it could amount to abuse. The preparation of data analysis memos offered an opportunity to reflect upon the breadth of the proposed themes, including those related to “abuse” or “best interests”.

iii) Reflexive Accounting

Approaches to qualitative analysis require differing attention as to the role of the researcher. In some positivist traditions, the role of the researcher is something to be put aside. In other approaches, the identity of the researcher is an integral part of the interpretation project.\textsuperscript{479} Elliot and Timulak (2005) asserted that bias is “unavoidable” and that “knowledge is impossible without some kind of previous conceptual structure.”\textsuperscript{480} The identit(ies) of the researcher influences the research process. Hammersley and Atkinson (2007) characterized “reflexivity” in the following way:

\begin{quote}
... the orientations of researchers will be shaped by their socio-historical locations, including the values and interests that these locations confer upon them. What this represents is a rejection of the idea that social research is, or can be, carried out in some autonomous realm that is insulated from the wider society and from the particular biography of the researcher, in such a way that its findings can be unaffected by social processes and personal characteristics.\textsuperscript{481}
\end{quote}

Creswell and Miller (2000) argued that the choice of validity procedure depends on the “the lens researchers choose to validate their studies and researchers’ paradigm assumptions.”\textsuperscript{482} Reflexive accounts are “clearly positioned within the critical paradigm where individuals reflect on the social, cultural, and historical forces that shape their

\begin{footnotes}
\item[479] Eakin & Mykhalovskiy (2002), supra note 473 at 191: “With regard to the role of the researcher, a substantive approach would be based on an understanding of researcher subjectivity not as a problem of bias to be eliminated or reduced (or at least confessed) but as something to be used actively and creatively throughout the research process.”
\item[480] Elliot & Timulak (2005), supra note 477 at 148.
\item[481] Hammersley & Atkinson (2007), supra note 450 at 15.
\item[482] Creswell & Miller (2000), supra note 470 at 124.
\end{footnotes}
interpretation.” Critical qualitative methodologies reject the positivistic notion that scientific inquiry should be value-free. Indeed, critical theories posit that socially constructed relations of power mediate the production of knowledge and data.

As a “validity procedure”, Creswell and Miller (2000) suggested that “researchers report on personal beliefs, values, and biases that may shape their inquiry.” I have worked to acknowledge (rather than put aside) my presuppositions, biases and previous knowledge. To be forthcoming about my own influence on the data, I adopted a self-critical approach. Rather than hide or negate my own attitudes towards the data, I strived to be honest about how my positionality influenced the construction of the data.

Despite the social sciences’ “reflexive turn”, there is limited guidance in such literature about how to establish reflexivity. Mauthner and Doucet (2003) reflected on the possibilities and limits of reflexive accounting. Lynch (2000) challenged the over-emphasis on “garden-variety methodological self-criticism.” Creswell and Miller (2000) suggested that researchers’ “create a separate section on the “role of the researcher,” provide an epilogue [and] use interpretive commentary throughout the

484 Creswell & Miller (2000), supra note 470 at 127.
485 Thomas H Schram “Establishing Your Perspective” in Conceptualizing Qualitative Inquiry: Mindwork for Fieldwork in Education and the Social Sciences (Columbus, Ohio: Merrill Prentice Hall, 2003) at 32: “Assumptions are also at work to influence the particular way you look at society and social phenomena. Once again, making these assumptions explicit is important for understanding, and making clear to others, why you attend to some things but not to others in the conduct of your inquiry.”
486 Michael Lynch, “Against Reflexivity as an Academic Virtue and Source of Privileged Knowledge” (2000) 17:3 Theory, Culture & Society 26 at 26: “Reflexivity, or being reflexive, is often claimed as a methodological virtue and source of superior insight, perspicacity or awareness, but it can be difficult to establish just what is being claimed.”
488 Lynch (2000), supra note 486 at 36. “Reflexive analysis is often said to reveal forgotten choices, expose hidden alternatives, lay bare epistemological limits and empower voices which had been subjugated by objective discourse. Reflexive analysis is thus invested with critical potency and emancipatory potential. But, as I have argued, what reflexivity does, what it threatens to expose, what it reveals and who it empowers depends upon who does it and how they go about it...”
discussion of the findings.” Also in Chapter 6 (“Reflexive Accounting”), I drew from Elliot and Timulak’s (2005) approach to “constant critical (but not paralyzing) self-reflection and challenging skepticism with regard to the analysis, methods and the emerging results.”

I prepared a reflexive journal, in the form of a thought-stream, through most stages of the research. I personally reflected on my values, assumptions, and life experiences, and considered their impact on the interviews and focus groups and the subsequent reporting of them. I thought of the journal as a place to record my thoughts. I took notes about my reaction to participant responses and recorded unusual or unexpected interactions or occurrences in the interviews as well as my thoughts or feelings about them. In the journal, I aimed to “look suspiciously at [my] own observations, asking where [I] might have applied [my] own biases and interpretations instead of those generated from the actual behaviors, interactions, words and sentiments of [my] participants.”

V. RESEARCH ETHICS

Recruitment commenced once ethics approval had been obtained from the Health Sciences Research Ethics Board (REB) at the University of Toronto. The research first received REB approval in April 2012. The REB approved an amendment to the research protocol in January 2013.

This study posed minimal risk to participants. Persons with current or past experience with the psychiatric system were not directly recruited. No participant identified herself or himself as having personal experience as a patient in a psychiatric setting.

490 Elliot & Timulak (2005), supra note 477 at 152.
Early on, responsible reporting of the findings was determined to be important to reduce the likelihood that patients, ex-patients or future patients could misinterpret the findings to be that covert medication is commonplace. To address this risk of misinterpretation, the research findings will carefully frame the results. Partnerships will be developed with community or advocacy organizations to help optimize responsible knowledge exchange.

At the focus groups and interviews, Consent Forms were distributed [Appendix D]. These forms included a “confidentiality clause”, warning participants that confidential information may be disclosed during the focus groups. The Consent Form also emphasized that participants may choose to drop out at any time or refuse to answer specific questions.

Professionals participated in focus groups and individual interviews. Given the topic’s sensitivity, HCPs may have been anxious about talking about the subject. Prior to the outset of the interviews, I drew participants’ attention to the Consent Form (“Privacy and Confidentiality”), which asked participants to refrain from commenting on specific clinical experiences. During the interviews, I carefully monitored the discussion and was prepared to remind participants to focus on the fictional clinical scenarios. No participant commented on specific instances of the covert administration of medication within their own practice.
CHAPTER 6: RESULTS

This chapter summarizes key findings from this study’s two data collection phases:

1. **Document Analysis**: Policies and practice guidelines that govern the covert administration of medication were collected from all facilities designated under Ontario’s *Mental Health Act* to provide psychiatric services, including on an inpatient basis.

2. **Focus Groups and Individual Interviews**: Three focus groups and three individual interviews were conducted, relying on a discussion of three clinical case scenarios of the covert administration of medication. Stakeholders included (1) legal experts, including patient and ex-patient advocates, (2) nurses with inpatient psychiatric nursing experience and (3) psychiatrists. The clinical scenarios (Appendix C) highlighted particular legal issues related to the covert administration of medication and were developed with the assistance of three psychiatry residents.

Each of the three Research questions, below, is explored in turn. Where appropriate, this chapter draws on data from each of the two data collection phases.

1. What are the common themes of institutional policies, clinical protocols or practice guidelines that apply directly or indirectly to the covert administration of medication?

2. What is the understanding of (1) legal experts, including patient advocates and ex-patient advocates, (2) nurses with inpatient psychiatric nursing experience and (3) psychiatrists of the impact of covert administration to the rights-situation of incapable adult inpatients in psychiatric settings?

3. What are the socio-political-legal structures underlying the practice of the covert administration of medication to adult inpatients in psychiatric settings?
These findings are not organized according to each of the three clinical scenarios. The conversation at both the focus groups and individual interviews was intentionally free flowing, and some of the discussion did not expressly consider specific scenarios.

I. RESEARCH QUESTION 1: WHAT ARE THE COMMON THEMES OF INSTITUTIONAL POLICIES, CLINICAL PROTOCOLS OR PRACTICE GUIDELINES THAT APPLY DIRECTLY OR INDIRECTLY TO THE COVERT ADMINISTRATION OF MEDICATION?

This Section draws on the rights-based approach, as set out in Chapter 2 (“Theoretical Frameworks”).

i) Institutional Policies, Guidelines and Protocols

The review of all Schedule I facilities in Ontario determined that there are two psychiatric facilities in Ontario that have an express policy, guideline or protocol that governs covert administration. The following documents are included at Appendix E (“Covert Medication Policies”):

- Centre for Addiction and Mental Health, “Covert Administration of Medication” (PC 2.3.3) (effective December 2012). The policy was significantly revised in 2012.
- Ontario Shores Centre for Mental Health, “Medication Administration” (2013). There were 2001 and 2010 policies that were specific to the use of concealed medication. The 2010 policy was rescinded when the 2013 Medication Administration policy took effect.

Background documents related to the development of these two policies were also gathered. Freedom of information requests were made to both CAMH and Ontario Shores for “background reports, memos, minutes of committee meetings or other related documentation.” There was very little documentation of the Ontario Shores policy. Disclosed documents (14 pages) included generic forms and committee meeting
minutes.\textsuperscript{494} However, 530 pages of documents were disclosed by CAMH and revealed the following information:

- The CAMH policy originated in the Geriatrics program where covert medication practices are used “almost daily”.\textsuperscript{495}
- The practice may be used on occasion in the Schizophrenia\textsuperscript{496}, Law and Mental Health program\textsuperscript{497} and the Women’ program\textsuperscript{498}. The practice was used more often in the Dual Diagnosis unit.\textsuperscript{499}
- Crunchy peanut butter and mashed potatoes are preferred vehicles to deliver medication covertly.\textsuperscript{500}
- Commentary on the practice was mixed at CAMH and included the position that the practice cannot be justified where the person is likely to regain capacity.\textsuperscript{501}

There was a range of opinion both for and against its use.

A thematic content analysis of the available policies was planned in order to identify common themes and protections. This was made impractical given that there were only two policies available and that the Ontario Shores policy was very short. Both policies, however, were clear on the following items:

- The practice is only considered for patients who are incapable of giving consent; and
- An SDM must explicitly consent to the concealment.

\textsuperscript{494} Ontario Shores Centre for Mental Health Sciences, Documents disclosed in response to author’s Freedom of Information Request (6 January 2014).
\textsuperscript{495} Centre for Addiction and Mental Health, Documents disclosed in response to author’s Freedom of Information Request (30 July 2013) at 0158.
\textsuperscript{496} CAMH - FOI, supra note 495 at 0165.
\textsuperscript{497} CAMH - FOI, supra note 495 at 0165.
\textsuperscript{498} CAMH - FOI, supra note 495 at 0166.
\textsuperscript{499} CAMH - FOI, supra note 495 at 0172.
\textsuperscript{500} CAMH - FOI, supra note 495 at 0176.
\textsuperscript{501} CAMH - FOI, supra note 495 at 0194.
It does not appear that there are any other policies, guidelines or protocols at other psychiatric facilities in Ontario or in other Canadian jurisdictions. The researcher also reached out to psychiatric settings across the country, including all territories and provinces.

ii) Guidance from Professional Organizations outside of Ontario

Relevant guidance from professional organizations of health care providers, including physicians and nurses, was reviewed. Three relevant documents were identified:

- College of Registered Nurses of Manitoba, “Interpretative Document: Covert Medication Administration – Code of Ethics Application” (2006); and
- College of Registered Nurses of Nova Scotia, “Medication Guidelines” (2011); and

All three guidance documents emphasize 1) that the practice must be used as a last resort, 2) the value of a trusting and respectful relationship and 3) that the practice warrants careful analysis. However, the three documents vary in the degree to which they explicitly reject or support the practice:

- College of Registered Nurses of Manitoba: “You are involved in a potentially serious legal and ethical violation that needs to be addressed immediately. ... Health care providers are obligated to advocate for patients and work to resolve practice issues such as this one.”

- College of Registered Nurses of Nova Scotia: “This practice disregards a client’s right to informed consent and her/his right to refuse medications. Covert medication administration also breaches client trust, violates the Code of Ethics

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502 College of Registered Nurses of Manitoba, supra note 311 at 1.
for Registered Nurses, and is a misuse of a registered nurse’s professional status.”\(^{503}\)

- College of Registered Psychiatric Nurses of British Columbia: “The CRPNBC Code of Ethics and Standards of Practice do not support the practice of administering covert medication.”\(^{504}\)

Professional organizations of physicians did not offer express guidance to doctors about the practice.

II. RESEARCH QUESTION 2: WHAT IS THE UNDERSTANDING OF (1) LEGAL EXPERTS, INCLUDING PATIENT ADVOCATES AND EX-PATIENT ADVOCATES, (2) NURSES WITH INPATIENT PSYCHIATRIC NURSING EXPERIENCE, (3) PSYCHIATRISTS OF THE IMPACT OF COVERT ADMINISTRATION TO THE RIGHTS-SITUATION OF INCAPABLE ADULT INPATIENTS IN PSYCHIATRIC SETTINGS?

Relevant to Research Questions 2 and 3, data were gathered through focus groups and individual interviews with legal experts, nurses and psychiatrists. Drawing on grounded theory, data were coded on a line-by-line basis. Data were contextualized and "made sense of" by constructing and reconstructing emergent themes and paying special attention to negative cases. Upon initial analysis, emergent themes (and sub-themes) were identified. After reflection and further analyses, a typology of themes was developed. Figure I (“Conceptual Map”) summarizes the findings diagrammatically.

Participants did not identify particular laws, policies or practice guidelines that governed the administration of medication. Participants in the legal focus group characterized general provisions of the HCCA as possibly influential to understanding the legality of covert medication. Participants were, for the most part, unable to point to an institutional policy (including participants who worked at the CAMH where there, in fact, is a policy).

\(^{503}\) College of Registered Nurses of Nova Scotia, supra note 312.

\(^{504}\) College of Registered Psychiatric Nurses of British Columbia, supra note 313.
Nevertheless, participants in the nurse and psychiatrist focus groups described the practice of covert medication as extraordinary. None of the legal participants had encountered the practice of covert medication in a psychiatric setting (although one participant had encountered the practice in the developmental services sector).

During the analysis, it became difficult to distinguish differences between responses from each of the three stakeholders. As set out in Chapter 1 (“Introduction”), this research did not aim to disentangle the psychiatrist-, nurse- and legal-participants’ commentary on the impact of the practice. Rather, the responses from the three sets of stakeholders are reviewed together in this chapter.

DESCRIPTIVE: Covert Medication Belongs to a Range of Practices

Initial data analysis highlighted other medication practices in psychiatric settings that constrain and/or coerce patient choice. These strategies vary in how passive or active they are in their use of deceit or coercion. They also varied in the extent to which they constrained patient choice. These examples resonated with me, suggesting that covert medication ought to be considered within the context of hospital practices. For instance, one participant in the focus group of legal experts contextualized the practice:

SPKR_E:..I mean, covert medication is out there as a strategy, but in terms of compelling capable or incapable people to follow a particular treatment uh, regime, I don't think it's - it's an extreme, but I don't think it's like something out in outer space. I think it's -
SPKR_A: It's not anomalous.
SPKR_E: That's right, it's not anomalous, it's part of a continuum that's driven by the understanding of healthcare providers, their sense of obligation in terms of following the law and also the protections that are available for people.

For example, HCPs may advise patients determined to be incapable of making treatment decisions that they have to take their medications, but that it was up to them as to how they were going to take it. Patients were advised that either they would take the medication on their own, or they would get the same medication as a chemical restraint
by injection. One participant in the focus group of psychiatrists described strategies to ensure that resistant patients are medication compliant. In that scenario, Chenglei was involuntarily admitted to a hospital after he stopped taking lithium. While in the hospital, he also refused the medication Valproic acid despite the fact that his substitute decision maker had consented to it.

SPKR_E: Yeah, we wouldn’t consider going this route, I think. For whatever reason, it doesn’t appear on our radar. We would say, “Chenglei, you’re getting medication, and you can choose the route. You can have oral medication, or you can have injectable medication—-

SPKR_E: -- and that’s it.”. And, then it would be up to Chenglei which way he’s gonna take it, basically. And if he didn’t -- if he refused oral, we’d get a needle, and if necessary we would get security, and we would hold him down and give him the needle.

INTERVIEWER: Is that -- is that like what you just said about being, um, preferring to be upfront and coercive?

SPKR_E: Yeah....

SPKR_A: We would prefer not to be coercive - we start off the other way. [Cross talk]. [Laughter]

SPKR_E: Yeah, no. But, when it comes to this kind of a point -- ....-- yeah, we wouldn’t do this, we would, uh, we would just, like, inject him, essentially. And, he would know full well what we’re doing even though he didn’t agree with it.

Another participant in the psychiatrists’ focus group described “coercive compliance” this way:

I’ve never specifically struggled with something like that. And, if so, then ECT would be brought to the table and, uh, generally I think people would be afraid to go ahead with ECT, and we’d get them to comply at that point, sort of coercive compliance with ... medications, without resorting to hiding it in food....

Similarly, health care practitioners may advise a patient determined to be incapable of making treatment decisions that medications were “vitamins” or “Tylenol” in order to encourage medication compliance. One participant in the focus group of nurses
described the patience required to work with individuals who have dementia and who have forgotten that they refused medication:

SPKR_B: Not really, because, sometimes with people with dementia it is just kind of hit and miss. Just like PARTICIPANT NAME said, five minutes later you can go say, "Here is the medication." They are like, "Oh, thanks dear. Great."

SPKR_A: They forgot they are refusing.

SPKR_B: Or, they forgot that it was offered five minutes before. Dementia is a whole different ballgame than any other mental health issues. But, yeah, I have definitely for people who are suffering, particularly if they are agitated. It -- I mean it's important to get the medication and, but they have rights too if they refuse. But, if they're agitated...Agitation with dementia, whether they are restless and they can't sleep, and they are just go -- go -- go, and you can see it riling up. Yes, I will absolutely offer them medication and say here's your vitamin, because I know that within a half or 45 minutes, really we're going to have to physically hold them down, which terrifies them. We are going to have to hold them down, cast of thousands and give them an injection, and that is what I want to avoid. So, I would really only do that with somebody who was very anxious, or agitated and demented.

SPKR_C: Which is painful for that person to be in that state. It is probably--

SPKR_B: Exactly, I see that as a more ethical choice, to lie about what it is. And actually it is lying, it's tricking them.

A participant in the focus group of nurses considered the practice of leaving juice mixed with medication at the patient’s bedside.

But, I don’t think all three of us sitting in this room, all of us are aware, at times, throughout our career where liquid meds would be put in juice and left at the patient’s bedside. Because that patient would drink juice, for somebody who is psychotic let’s say, and, they will not take the medication, they won’t take it, they won’t take it. And so, it is put in juice and left at their bedside and they drink the juice. It’s like, yeah, they had it in an orange juice. It happens. I don’t know how often, but it does happen and I’m sure you have seen that PARTICIPANT NAME, and you too PARTICIPANT NAME.
Another nurse-participant described a “role-playing” strategy to encourage medication compliance. Nurses speak to each other in front of the patient about the benefits of a medication without the patient knowing that the nurses intended for the patient to overhear the conversation.

SPEAKER: So, the other thing I'll say is sometimes there's kind of role-playing that happens[...] So, when someone is really ill and they're going to hurt themselves, essentially[...] and they need to take a medication to be able to relax and to be able to not hurt themselves. [...] We don't want to put people on restraints if we don't have to, so, um, sometimes you might say, uh, you know, you might role play to try and set the situation up so that the patient feels comfortable taking the medication because they're really ill.

INTERVIEWER: Okay. That’s interesting. Role playing.

SPEAKER: Yeah.

INTERVIEWER: Okay. Like, um—

SPEAKER: I'm just trying to think of—.

INTERVIEWER: Okay. Like, is that kind of like health teaching that...

SPEAKER: I guess in, like, a very bizarre way, yeah.

INTERVIEWER: Yeah. So, like, the two different nurses role-playing, or you—.

SPEAKER: Yeah, and interacting with the client. Like, coming in and saying, like, “This new medication is going to do wonders”, and the other nurse might, kind of, jump on board and say, “Oh, wow, I heard about that. That's supposed to, like, really help people when they're stressed out”, or, I don't know, it's like a very......just a way to kind of, kind of have a conversation where the person is like, overhearing it and then they are offered it, I guess[ ...]

INTERVIEWER: Is the person aware that this is a role-play, or do they—?

SPEAKER: I don't think they know that it's a role-play because they're really sick. [...] Like, that, that's kind of the point. So that they take the medication and don't hurt themselves. So, it's not hiding in food, but it's kind of like a way of, um, making the situation favourable so the person is more likely to take it rather than having to—. Like I said, we're always trying to avoid any sort of aggression or violence.
Other examples of coercive practices included coaxing, limiting privileges (like outdoor time)\textsuperscript{505} or bringing hospital security to the incapable patient's bedside to monitor medication compliance. Most participants offered examples of ways to avoid covert medication, suggesting that covert medication was considered only as a last option.

**IMPACT: Access to Knowledge**

Participants considered the practice's impact on access to knowledge by patients, SDMs and HCPs. Knowledge was interpreted broadly to include information, support and education. Participants also raised questions about access to justice including to access to complaint mechanisms.

**PATIENT: Access to Knowledge**

All participants considered how covert medication impacted patients' access to information about treatment. These questions were raised often and in all three groups. In particular, participants described covert medication as precluding the patient from participating in treatment decision-making. In this way, the whole health care team knows about the practice. Rather than being part of the team, the patient becomes a subject of surveillance. One participant in the focus group of legal experts put it this way:

> Maybe you're incapable but you're not gone.

Another participant in the legal expert focus group considered the same issue:

> And um, there isn't any viable way to assess whether the person's capacity is fluctuating in this scenario because they're not engaged in the process.

\textsuperscript{505} One psychiatrist participant put it this way: "You can do coercive things too, like if they're involuntarily in hospital they won't get passes unless if they take their medications, right? Cuz that's a sign of health, right? So, there's ways of being transparent about expectations of treatment, right? And so... Um, I don't know what to call it."
Another participant in the legal focus group commented on the second scenario in which Chenglei is covertly medicated with valproic acid following his refusal to take it orally:

Um, so here there's Chenglei in the hospital, he's saying he has been told about valproic acid because he's consistently refusing it. They find him incapable, he's in hospital, obviously a bit agitated, and all of a sudden he's feeling better and he leaves. I mean, how is he supposed to attribute any of the change in his behaviour to the benefits of the medication? He hasn't even been given a chance.

A participant in the legal group addressed his concern that the practice made it impossible for patients to look out for side effects and report them to HCPs:

It is very hard to track side effects when you don't know that you are receiving medication. [...] I say, you don't know we were taking medication. If you don't know that you're -- whatever you're experiencing physiologically or, in terms of your thinking, you wouldn't necessarily know or hazard to guess that you were being medicated- essentially against your will and without your knowledge.

Participants in the legal expert focus group compared the impact of covert medication to the impact of physical restraint on a patient’s access to information:

SPKR_E: There's something about this that parallels restraining somebody physically to - to inject them if you will. Inherently, the tablet-form medication presupposes somebody who is willingly, voluntarily taking the medication. Any physician will tell you, on any level, you can't compel somebody - you can't strap them down and force them to take a pill. So this is kind of an analogue, like hiding a pill in food is an analogue to physically restraining somebody. It's been - they seem different but they're not. Because you're overcoming the persons' will.
SPKR_C: Yeah I think there are a lot of parallels - [Crosstalk]
SPKR_F: In my mind it's almost worse, because if I'm being held down, and injected, I cognitively know something's not right here, and so if I have no idea - it's worse. But at least I know.
SPKR_E: I mean it's your worst nightmare of psychiatric treatment. You're deceived and then you are compelled to take something that could alter your thinking and alter your physiology, potentially the most extreme situations result in your death. And, where you lose all control. I mean, the person's not a willing participant on any level, and they're not asked to be,
they're not invited to be. SPKR_C: And they're not even told. The difference with the restraint piece is at least they know.

Nurse-participants raised questions about patients' access to information about their treatment during the discharge process. A patient may be discharged from hospital with a prescription for a medication that they did not know they were taking. One participant describes this situation:

SPKR_C: Then the patient would say, "Where did you get that from? I wasn’t taking medication while I was [cross talking]."
SPKR_B: So, this does not really kind of make much sense to me. This is not a scenario that I could ever imagine happening.
INTERVIEWER: It’s really interesting though that you have raised that, because not only is it important for the patient to understand -- Like, what I hear you saying is that it is important for the patient to understand why they have gotten better, but it is also important for them to continue to remain well in the community.
SPKR_B: That’s a huge thing.
INTERVIEWER: Is that right? So, the importance for knowledge in the discharge process...
SPKR_B: Discharge. It is a whole discharge-planning thing, yes. And, we discussed that with the patient prior to them going, and a patient like this would not just be discharged from hospital without a prescription and follow-up appointments.

A nurse-participant in an individual interview also considered the impact of covert medication on the discharge process. She pointed to the third scenario in which the patient’s SDM did not explicitly consent to the hiding of the medication. Even though she consented to the medication, the SDM was upset when she discovered the fact of the medication’s concealment.

Um – well like you can’t – you can’t physically force someone to take an oral medication, so it’s just – I don’t know – policy, I guess that’s a health care professional thing. Like you can’t – it’s the same thing with someone who’s not eating and drinking, you can’t physically force food on – like you can restrain them and give them IV, like, nourishment but you can’t – you can’t force that. Really it’s assault if you do. Um, but yeah like – we’ve – like I would totally agree with the niece. I would be upset if I found out they were
hiding it. Because, you know, if you made her incapable and you didn’t consult her with that specific method – ‘cause it’s violating the patient’s rights. [...] – the patient has a right to know what’s being given to them and why. And even if they don’t have the capacity to understand it, it still needs to be stated to them. Like and you, the doctor – I know it’s not great for therapeutic alliance sometimes – but right now you’re too ill to make your own decisions, your niece is your substitute decision maker. She’s agreed for you to get this medication she thinks – she agrees with the doctor it’s going to be helpful for you, beneficial for you. This is why we’re giving it to you.

Legal-participants also raised questions about the practice’s impact on access to justice. A patient is not aware of the fact of the administration of the medication. It is also unclear that the SDM must expressly consent to the concealment. As set out in Chapter 3 (“Legal and Governance Landscape”), Ontario’s Superior Court in SMT v Abouelnasr found that the SDM consents to the ‘treatment package”, which includes the application of restraints. It is unclear whether this applies to the concealment of medication in food or drink. If the SDM is not required to explicitly consent to the covert administration, it may be that neither the patient nor the SDM would be aware of the fact of the covert administration of medication. Neither the patient nor the SDM has access to the information necessary to challenge the decision to conceal the medication. This information-barrier was expressed by one legal-participant:

I mean it is one thing to be medicated against your will, but it is another thing to be medicated against your will and without your knowledge. There is no chance of exercise any rights whatsoever.

SDM: Access to Knowledge

Participants raised questions about the impact of covert medication on SDMs’ access to knowledge. There was general concern about whether HCPs give SDMs enough information to make a decision to covertly medicate. SDMs’ access to information to make an informed decision indirectly impacts the right-situation of patients. The consent taking process may be very broad, glossing over the details and failing to explicitly consider the hiding of the medication as stated by a legal focus group participant:
SPKR__B: ... But, what strikes me the most of all the issues that everybody's bringing out here is "knowledge". Knowledge seems to me to be the most central problem and um, so his knowledge first of all, but also the wife's knowledge, right? Like, you know, there's different kinds of family members and some of them are problematic and some of them mean well. And you know, this may be a very well-meaning wife who doesn't know what to do, and the doctors tell her this is what you're supposed to do, so her knowledge, too.

SPKR__C: That she might have gotten from the family doctor. [Crosstalk]

SPKR__B: She needs to - you know, have access to education and information and rights for her as much as for him, because she's probably - you know, she may well be pressured and scared.

There was confusion about whether SDMs must be provided with enough information to consent explicitly to the concealment. It was not clear whether the SDMs must be informed about the specific benefits and dangers of hiding medication, including a potential impact on therapeutic alliance. One participant in the legal group considered the second scenario, where Chenglei's father is the SDM.

SPKR__A: [...]there's nothing about the doctor's conversation with the father. I mean, the father should be making an informed decision. The doctor has the obligation to ensure that the consent is informed consent. To what extent did the doctor have a discussion with the father about the risks and benefits? You know, it sort of implies here again without further information that the substitute decision maker is entirely complicit with the health care team's uh, coercive treatment of the patient. Um, so again the issue of a substitute decision maker being informed of their obligations, and uh. You know - frankly, if I was in this situation and I found out that the father had given consent without being fully informed, that would be grounds for a complaint against the doctor, a suit against the doctor, suit against the substitute decision maker. I mean, who's getting this advice? [...] SPKR__F: Right.

SPKR__A: Right? Like I mean, the system is set up to be very - there was a revolution in giving patients more autonomy, but in practice - SPKR__C: Right. I mean that’s one of the realities. It’s a flaw in the system because typically the SDM’s are lucky if they even get the basic - here are the material risks and the potential benefits, and here are the alternatives, and here’s what we might do - much less a good grounding in what does it mean to be an SDM.
The legal-participants made the following additional comment about the information owed to the SDM in order for the HCPs to assure themselves that they have the consent necessary to covertly medicate:

SPKR_E: And it also occurs to me that when an SDM is consenting to this form of treatment, and maybe the hiding the medication. This is an ancillary piece of treatment, are they given the opportunity to specifically consider consenting to that part of it? Like, so you weigh the risks to benefits, side-effects, gains and so forth. But, now does the doctor actually sit down and talk about what are the potential negative consequences of administering medication in a covert way - because that speaks to another part of your treatment, which is - covert administration is an ancillary treatment.

SPKR_F: Right.

SPKR_E: So, are SDMs going to have a chance to chew that over? And did Chenglei know or did his father know, or was he informed that this could go, you know belly-up. If your son finds out he may get very angry at you and he may disengage from treatment. That's a risk.

The psychiatrist-participants reacted in the following way to the final scenario, where the HCP team fails to get explicit substitute consent to covertly medicate a patient.

SPKR_E: So, I wouldn't do this.

SPKR_A: Yeah.

SPKR_C: Yeah, I think none of us would.

SPKR_E: You need to get the consent --

SPKR_C: Yeah.

SPKR_E: -- before you start playing games like this. Um, and if the niece isn’t returning calls, then you need to find an alternative substitute. Or, if not, call the public guardian and trustee, but someone has to provide consent.

There were questions about whether SDMs have access to education about their HCCA obligations. For instance, the HCCA requires that the SDM make decisions in the patient’s best interest. There may be significant disagreement between the HCP and the SDM about what constitutes “best interests”. Participants also considered the likelihood that, where an SDM refuses to consent to proposed treatment, the HCP may apply to CCB to remove that person as an SDM. This point was acknowledged by the physicians:

SPKR_C: The SDM can say, “No, I don’t want my son to be held down by a
security trained gentleman,” and you have to respect that.
SPKR_A: Yeah. [...] 
SPKR_A: Well, I mean, yeah, but also the person suffering in hospital when
we think they’re not making an informed decision, then we’ll try to -- we’ll
apply to have the SDM removed as best as we can.
SPKR_C: Yeah.
SPKR_E: But, that -- I’ve never done that.
SPKR_A: I’ve never done that, either. [Cross talk]
SPKR_A: Sometimes parents -- well, sometimes SDMs need a little more
education, uh, and you’re like, “Listen, these are the alternatives, like they
stay here forever in a hospital in this state...”. [crosstalk]
SPKR_C: or on the street or in shelters.
SPKR_B: They end up getting the restraints anyways, because they’re so
agitated and harm to themselves [over talk]
SPKR_A: And, then they end up getting needles anyways, because there’s
difference between administration of medication and then chemical
restraints, and then there’s -- it’s dangerous for staff, or other patients if we
have to give them chemical restraints, which are the same medications, just
for a different indication. [...] 
SPKR_A: Um, so they, um, are gonna get it anyways -- [...] 
SPKR_A: -- except, and if -- and at unknown times and in a more coercive
setting even than that, so...

HCP: Access to Knowledge

Participants also raised questions about access to education and available support for
HCPs about their professional obligations. As example, there was confusion in the nurse
and psychiatrist focus groups about the availability of laws, policies or guidelines to
guide the covert administration of medication. In an individual interview, a nurse-
participant commented about how laws, policies and practice guidelines applied to a
scenario:

Again, I guess, that’s pretty – I haven’t reached that much, that level yet[...] 
where I would just be, like, okay let’s call in some [...] help to get more
education on that [...] because I really, can’t really say.

A legal participant made a similar comment about HCPs’ understanding of their legal
obligations, as it applied to the covert administration of medication:
[I]t's part of a continuum that's driven by the understanding of healthcare providers, their sense of obligation in terms of following the law and also the protections that are available for people.

This exchange between psychiatrists describes their understanding of the availability of institutional policies:

INTERVIEWER: Any other thoughts about how -- what kind of laws might -- and not just laws, I mean, guidelines --
SPKR_C: Yeah. I think CAMH guidelines are, I don’t know, because again, we’re not encountered with this scenario so often, and maybe the geriatric staff is encountered with this scenario, that there’s an incapable patient, and there’s a substitute decision maker. Isn’t there a general policy, however, at CAMH that we do not administer under any circumstances, even with such substitute consent medications in…?
SPKR_A; No we do actually. [Cross talk]. [Laughter]

There were general questions about the support available for HCPs to deal with complex issues of the kind raised by the three scenarios. One participant in the legal focus group put it this way:

I think that a lot of healthcare providers play fast and loose with their obligations in law. You see this all the time, and I think there is no - there doesn't seem to be any, um, education that's required of them and educational, sort of continued education, respecting and understanding of what their obligations as a health care provider are.

The same legal-participant made an additional comment about HCPs' obligations as related to the Health Care Consent Act, including their professional obligations, including as set out by the College of Physicians and Surgeons of Ontario (CPSO):

... there are specific guidelines respecting the doctor's role about involving the incapable person in decision making, not just the SDM. But, under practice guidelines that the CPSO set out for physicians. So right off the bat the doctor is not adhering to his or her own obligations. You know, based on the College's guidelines, specific to treatment.
There were related questions about whether HCPs must get medication “into” an incapacible patient where substitute consent had been obtained. One of the nurse-participants commented on the first scenario, where Manhor’s wife consents to the hiding of liquid fluoxetine in his tea:

My reaction when I read this, right away, his substitute decision-maker is his wife. He is being found incapable of making treatment decisions. He has a substitute decision maker. This is all legally in place, therefore, we do what we have to do to medicate them, if that is what the substitute decision-maker says.

One nurse participant in an individual interview addressed the barriers to keeping up to date with best practices:

So, my biggest admission, when it comes to legal and best practice guidelines [...] is that medication administration is one of the many, many things that nurses do [...] and so it’s really difficult to keep on top of, um—what is the best practice for [...] each scenario, whether it be medication administration or something else. Um, and I know it’s a very conscious effort on the part of, of, certainly, nurses that work in scenarios like this [...] but also of organizations to set their staff up for success [...] so that they’re not doing bad practices [...] But also not doing things that would have legal implications. So, my understanding of this is – I actually don’t know the laws when it comes to, like, hiding medications. Not that this is one of – well, I guess it is hiding because it’s in the, the tea. Um, I’ve never actually really thought of that, that, before. Um, it’s funny, when nurses talk after something like this there’s usually, like, a, “we’re probably not supposed to do that.” [...] We talk, we talk after something like this has happened [...] Where you’ve hidden something in jam or you’ve hidden something in tea, there’s always a, like, a conversation often, that happens in, uh, in the nursing station. It’s usually, like, “Oh we probably shouldn’t have”. Like, we probably shouldn’t be doing that but it’s for his or her best[...] interests and [...] I don’t – I think when they’re – my understanding is if you’re incapable, um, you don’t really have a choice.[...] So, the fact that it’s hidden, or you get an IM and security’s there, whatever. It’s – I, I don’t know if the route matters as much, but I, I don’t really know[...] But, it’s – this conversation’s making me nervous now. I’m going to go to the hospital tonight and now wonder, but...[laughing]
IMPACT: Trust and Truth

Most participants commented on the practice’s impact on the relationship between the patient and the HCP. The practice’s damage to “therapeutic alliance” has an indirect impact on the patients’ rights-situation. That is, if a patient has a trusting relationship with her HCP, there is less likely to be a legal breakdown.

Some participants took a consequentialist approach, pointing out that the long-term clinical implications (including interference with future treatment buy-in) made the practice less justifiable. One participant in the focus group of legal experts described the clinical implications of patient discovery of the fact of the covert medication administration. The participant refers to the first scenario in which Manhor’s wife concealed medication in his tea.

I also wonder about the impact, from a non-legal perspective, just the impact on the relationships. You know, one would hope that you would be working to towards good relationships with the treatment team, as well as with maintaining a relationship with the wife. If he is to find out down the road that wow, they were sticking stuff in my juice and I did not know about it, it could ruin those relationships and also make him unwilling to seek help in the future.

Participants in the psychiatrist group also raised the long-term impact on therapeutic alliance, referring to the second scenario:

Like, so, in this case, um, it looks like -- it looks like it blew up in their faces [Laughter]. Like, um, yeah, now he’s mad, he won’t call a psychiatrist, he won’t take any medication so it was kind of a situation like [...] Kind of winning the battle, and losing the war. [...] Like, yeah. Yeah, that -- I mean they treated him well in that episode. Who knows how it would have gone -- [...] like he would probably have been -- sounds like he’s mad. In this situation, he probably would have been mad if he’d been injected coercively during the admission as well, although, there are ways to deal with that.
A member of the legal experts group considered how covert medication reinforces some symptoms of mental health issues:

And, if one of the symptoms of the illness itself is paranoia and distrust, which are symptoms of many, many different types of mental illness, then you're only getting that feeling confirmed. And, it's going to be more calcified, and not pliable to treatment.

One member of the nurses’ focus group suggested that telling the patients about the fact of the covert medication - at the end of the inpatient stay and before transfer to the community - may repair the damage to the clinical relationship. This point was repeated during the nurses’ focus group. In the excerpt below, the nurse-participants refer to the second scenario where Chenglei discovers the covert administration of medication after discharge from hospital:

SPKR_B: Well, PARTICIPANT NAME brought up very early on in this session, "trust." It is all based on trust. And there you go, you have blown it. If that patient ever comes back to that unit ---
INTERVIEWER: Therapeutic relationship.
SPKR_B: Right.. it's not just that. I mean, probably with all, you know, mental health workers-- He has been tricked, he has been lied to, he wasn't told the truth blah, blah... Which, in fact, is true, whether he is ill or not, he was. So, unless it's kind of, unless it is explained and looked at and discussed with him, then, yeah, there goes that trust.
SPKR_C: And, not on the last day. No, I am saying you would want to talk about it with someone, and have him stay in the hospital for a little bit longer just to be sure that it is all integrated.
INTERVIEWER: Right, included in the discharge planning as you mentioned before.
SPKR_C: Well, of course, yeah. They always say, discharge planning starts on the first day of admission.

Psychiatrist-participants emphasized alternative approaches to covert medication as well as the value of outright coercion, in comparison to covert action.

Yeah, you have to -- I mean, I think the one thing that I'm often told, like, people -- with the surreptitious administration thing is, I think you're better off, you know, a lot of times, being frankly coercive rather than
surreptitious, because at least if you’re being coercive, then the person is like, you know, “You guys are making me do something I don’t want to do” but you’re being upfront about it, and they know that they can trust you even though they don’t -- like, they don’t agree with you, they think you’re wrong, etc. If you’re lying to them, and they find out, you can -- you will irreparably damage a therapeutic alliance. And then from that point on, they don’t know when you’re telling the truth and when you’re not. [...] I think, really you’re better off always telling the truth, even if it’s kind of an ugly truth.

There were additional questions about professional responsibility: whether lying by omission was permissible (including telling “little white lies”). One nurse in an individual interview described this “grey” area:

SPEAKER: Because even though they’ve been incapable of making consent to treatment decisions if they ask “did you put something in my tea?” you have to say “yes, I did”.
INTERVIEWER: You have to?
SPEAKER: We can’t lie to a patient. So yeah it’s kind of – like I understand this grey area where this is falling under, like I guess where maybe someone who isn’t actually providing care to patients – like, well if they’re incapable you could just put – they have to take it. So – it’s different for depression, but typically, in my experience, the patient is refusing to take oral – like, and this may sound worse. But for anti-psychotic medication if they’re refusing tablet form and their SDM has given consent for an injectable form, we give the injectable form if they refuse oral medication they eventually – after a couple experiences getting the injection they will accept the oral med and then they’re – and it’s okay. But concealing is like – it’s not – like I’ve never experienced that.

On the same issue, a legal-participant pointed out that a nurse must advise a patient, when directly confronted, if there is medication in her food:

SPKR_E: [...] I know from not studying any particular case, but I know from experience over the years, that there are ethical implications as well. I will state the obvious. Ethical implications in terms of the relationship with health care providers to their patients, right. So, what if, the patient says, -- to his nurse, his primary care nurse, "I think you are medicating me by hiding stuff. You are putting my medicine in my food, aren’t you?". Does the deception end there? Does the nurse declare, "Yes, we are," and, that is the end of this scenario? I mean, I think, many years ago I approached the
College of Nurses to ask what their policy was, and their advice, practice advice was to their membership. And, they took the position that, as long as there is SDM consent that the modality was not relevant that they were hiding it in the food that did not matter. However, if the nurse were outed, then he or she would be obligated to declare that indeed they were. So, they would not be able allowed to outright lie, but they could lie as long as the person is [inaudible].

SPKR_C: They could omit, if they were asked?
INTERVIEWER: So, it is a matter of professional ethics.
SPKR_E: Yeah, but I mean think he said, so whether you lie by omission because you never tell the person in the first place, or suddenly you are caught and you can't outwardly lie to your patient because that violates your basic practice guidelines, and speaks to the relationship. How can you have a trusting relationship if there is somebody doing things to you that. - - how can - - I mean nurses always talk about being, for example, because they are often the folks administering the medication - talk about being advocates for their patients. How can you advocate for your patient if you are part of this deception?

IMPACT: Recovery

Questions were raised about the impact of covert medication on how a patient recovers; response was split.

Autonomy Restoring

Some participants characterized covert medication as “autonomy restoring” since it assists someone to make their own decisions after a few doses. One participant, from the psychiatrist focus group, commented on the efficacy of chemical restraints (“needles”); however, this comment can also be applied to covert medication.

SPKR_A: With the sickest patients literally, like, one or two needles, and after that, they have the capacity to appreciate the coerciveness [Laughs], so they'll just take it orally afterwards.
INTERVIEWER: Okay.
SPKR_E: Yeah. Yeah, you rarely have to inject somebody, more than, like, once, because the first time maybe they don’t think you'll go through with it. You call security and you inject them, and the next day it’s like, “Okay, it’s time for your medication again. How's it gonna be?”. And then generally by
then they’re like “Enough already, just, I’ll take the pill.”

**Discharge**

Other participants commented on the impact of the practice on a person’s long-term prospects for “real” recovery. If patients do not know about the covert medication as they transfer from the inpatient unit, it may be difficult for them to remain healthy within in the community:

And the other thing is, how are you supposed to get back to capacity if you do not know that you are being treated? Like, how are you supposed to know the risks and benefits of the treatment that you are receiving when you do not know that you are receiving it?

Nurse-participants also commented on the impact of the covert medication on the discharge planning process:

**SPKR_B:** The last part of this to me, is like, like for instance, to me this doesn't really make sense because when the patient is better and discharged, even if the psychiatrist didn't have the wherewithal to disclose that you are better because -- not just the psychiatrist, the team, the nurses, whoever. It's mostly the nurses who spend time with the inpatients. Okay, they are lucky if they get five minutes a day with their psychiatrist, truly. So, but even if the nurses had not said, "Okay, you are better because we have been giving the medication in your juice." Part of the whole discharge-planning thing would be to discharge him on prescription meds. And so, that would be very unusual to have a patient in the hospital who magically got better, and then for the psychiatrist to say, "Okay, I'm ordering blah, blah, blah, valproic acid, here is your prescription for discharge, right." **SPKR_C:** Then the patient would say, "Where did you get that from? I wasn't taking medication while I was [cross talking]."

In this exchange, legal-participants considered the second scenario, where Chenglei is discharged from the hospital where he had been covertly medicated.

**SPKR_D:** So there's that part of it. And why would he continue treatment in the community? Like, what happens - so they've dealt with what was probably an acute phase of his illness, he's not doing well, all of a sudden,
he's feeling better, he leaves, but then what? He's refusing valproic acid and he has no idea that that's what made him feel better. And then, of course, there's the last bullet point where he's going to see his chart and he's like whoa, everyone lied to me.
SPKR_B: Including the father [...] [Crosstalk]

Additional clinical issues were raised by legal participants, including the danger that the patient will refuse to eat if she discovers the fact of the covert medication.

SPKR_D: As well, because sometimes, you know, people say, "I will not eat the food in the hospital. I think it is poison." I think what they really mean is, "I think they are hiding the medication."
SPKR_C: And they might be.
SPKR_D: It might be based on previous experience, but strategically, regardless of the legal stuff, I think it is not such a good way to deal with the issue.

Because mental health and wellbeing is key to the exercise of rights506, the clinical impacts of covert medication were determined to be relevant to the second Research Question about patients' rights-situation. As set out in Chapter 2 ("Theoretical Frameworks") and Chapter 4 ("Literature Review"), the protection of basic rights is fundamental to the promotion of mental health.507 As such, the practice's clinical impacts have an indirect impact on the patient's rights-situation (as set out by the second Research Question) and prospect for recovery.

**Patient Centeredness**

Other participants considered covert medication's impact on patient focus and engagement. The practice excludes the patient's perspective including about underlying reasons for refusing medication and the presence of unwanted side effects.

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506 WHO (2004), *supra* note 96 at 23: "A climate that respects and protects basic civil, political, economic, social, and cultural rights is fundamental to the promotion of mental health. Without the security and freedom provided by these rights it is very difficult to maintain a high level of mental health."

One legal expert considered the first scenario about an older man’s admission to a psychiatric facility, following his stay at home where his wife had administered medication in his tea:

Well, the other thing too that has occurred to me in this scenario is when - how long has his wife been administering his meds in his tea? Because, oh yeah, he drinks his chai, he doesn't drink juice, that kind of thing. So, this seems to have been a strategy for him over the long haul, even when he’s in community, and he's absent from the decision-making. He’s not - there is nothing client-centered about this approach.

Some participants considered the value of a recovery-focused practice that includes giving patients real options and allows for their inclusion in decision-making and goal setting. A client-centered approach is more likely to lead to recovery than reliance on strategies to improve compliance in the short-term. One nurse-participant in an individual interview put it this way:

Like other than – like in that specific situation? Um – I think what’s missing is – other than the fact – like, what the patient perspective is on this, like – why is he refusing other than he’s upset with being admitted? Like, has someone asked him what’s going on? Like, it sounds like – and really, is he – it says he tolerates. He doesn’t like taking it. Is there something about it doesn't like? Like it says he’d tolerated it well, but what, like really has it been helpful? In his experience.

The practice’s impact on recovery, in turn, impacts patients’ rights-situation. A person who recovers - and is discharged from the inpatient unit - may learn of the fact of the covert medication and challenge it. Chapter 7 (“Discussion”) will comment on the significance of the differences between participant responses, including how recovery is conceptualized and presumptions about likelihood of recovery.

**IMPACT: Best Interests**

During the focus groups and individual interviews, many questions were raised about how the practice impacts patients' best interests. This question was raised in many ways
and was the most diverse of the themes and the most difficult to conceptualize. There were a diversity of responses that elicited many questions: Is hiding medication better than restraining and injecting a patient? If medication is not covertly administered, will patients end up getting the same medication as chemical restraints? Can it be in someone’s 'best interest' to allow her to refuse medication capably? There were additional legal questions about the role that “best interests” should play in substitute decision-making and the way that medication (that has already been consented to) is administered.

Many participants commented on the relative value of covert medication over chemical restraints. One nurse-participant during an individual interview put it this way:

See, if he’s not willing to take oral meds and he’s that unwell – talk with the father. You have alternatives, like you can offer PO version of Epival and then you can – if they refuse it, they're incapable and they're – you know, very unwell and need treatment you can go a different route where you’re – you can give an atypical anti-psychotic that will help with mood stabilizing. Like, there’s other options. But it’s interesting because like while I’m saying "it’s awful to lie to a patient”, like the alternative is giving someone an injection which is not pleasant either.

One of the nurses in the focus group commented that it may be is in the patient's best interests to competently refuse medication. She raised a situation where a person is not capable, as in the case of dementia.

PARTICIPANT NAME just said about it being in the patient’s best interest, and I can only speak for myself, but certainly many of my colleagues that I’ve worked with, had the privilege of working with throughout the years, who are very experienced practitioners. It is always in the patient’s best interest, I find, if you are a compassionate and professional nurse then you always work in the patient’s best interest. And, sometimes it's in their best interest that if they are competent and they are refusing their medication then that is fine. They have the right to refuse. You write down "R" for refused on the Medication Administration Record. I mean, you have that right. If it is in their best interest to--if they are demented for example--then it is in their best interest to get the medication into them if they are going to be agitated and pacing and restless all night long. It is in their best interest to get the medication into them. But, I do not think that, I don’t think that there are
seriously a lot of nurses out there who, just for the sake of putting their initials on the medication record will say, "Okay, I've snuck that into that patient." It's always in the--we always, always first and foremost--what is in the patient's best interest.

This exchange between focus group nurse-participants is also illustrative:

SPKR_A: It's also easier -- it's hard on the nurse. It's awful to hold someone down.
SPKR_B: Especially, elderly people....It's more respectful to tell a little lie then to hold them down. [crosstalk]
SPKR_B: A little "white lie."
SPKR_C: Off white.
SPKR_B: Exactly. I don't think it happens a lot. I really don't, but it is certainly part of the whole ethical issue of administering psychotropic medication.

One nurse in an individual interview made this comment about the risks of failing to covertly medicate an at-risk patient:

I, I don't necessarily think it's -- when someone's incapable and they're at harm to themselves or others, the hiding is sometimes a safer and less, less risky, I guess you could say. Like, there's, like, you would hate to see this person, you didn't hide it in their medication, or you didn't have their medication in their juice, or whatever, and they deteriorated so much that they had a fatality or something [...] which is a very realistic thing that could happen

The nurse-participants in the focus group commented on the particular vulnerability of women with dementia. Covert medication was seen as a gentler approach that avoided conflict and was more likely to be in her best interests.

SPKR_C: The other thing is, you don't want to fight with a woman who has dementia. For what? You don't want to get into a power struggle with meds. I think it just agitates people unnecessarily. [Cross talking]
SPKR_A: You want them to be calm as possible and low-key. That's your whole approach is quiet, gentle, slow, you know, one task at a time.
INTERVIEWER: So fighting over medication..
SPKR_A: ...is counter therapeutic. [crosstalk]
SPKR_C: Good word.
Below, one nurse-participants refer to the second of the three clinical scenarios:

So, do you have a right to refuse medication? You have that right. I have to respect that. I don’t want people pushing it on me and I’m not going to push it onto…. I’m going to do what I can to get it into them, but I am not going to lie to them. Dementia is a whole new ball game, a whole new ballgame because they don’t have that capacity. In a situation like this, yeah, I would have done it. I would have got that medication into him in juice, absolutely. It was all – – this is all ethical. It’s unfortunate, but you have to get this man better. It is in the patient’s best interest. There is a substitute decision-maker. The whole team is on board. We know what we’re doing. The unethical part of it, as PARTICIPANT NAME said, is not telling him why he is better.

The nurses in the focus group also addressed the relative benefits of covert medication in comparison to injection:

INTERVIEWER: You just said, it’s not like its painful... Did you mean the ...
SPKR__A: The route?
INTERVIEWER: The crushing is not painful.
SPKR__A: Like taking it by mouth doesn’t cause pain.
INTERVIEWER: As compared to the IM?
SPKR__B: And, it’s safer.
SPKR__A: A needle doesn’t always hurt, but sometimes it hurts and people don’t like getting needles.
SPKR__B: And it’s riskier. There’s a lot more risk for injections--hitting a sciatic nerve. Whatever, this is safe. You said, she could take it by mouth, so she is taking it by mouth.
SPKR__A: Infection...

In the focus group of nurses, one participant made this comment about the motivation behind covert medication and how it relates to the patients’ best interests.

SPKR__B: ...But, I do not think that, I don’t think that there are seriously a lot of nurses out there who, just for the sake of putting their initials on the medication record will say, "Okay, I’ve snuck that into that patient.". It’s always in the--we always, always first and foremost--what is in the patient’s best interest.
A nurse in an individual interview also commented on the motivation to covertly medicate a patient, including to assist them through a difficult period of their life.

SPEAKER: Like, they’re – I guess my strongest point is that none of this is ever done maliciously…
INTERVIEWER: Yeah.
SPEAKER: …it’s always done to try and get that person through a difficult time and into a better place. And, if hiding in juice is the way to do it, I, I’m not necessarily against that. I think it’s, when hiding in juice is the way to do it and it’s because of the reason that the medication has a bad side effect, that’s where I have an issue…
INTERVIEWER: Right.
SPEAKER: …like that you haven’t fully explored other avenues.

However, two of the nurse-participants (in the individual interviews) shared their experiences working with patients who prefer injections to oral medication. A patient would refuse to take a medication orally, knowing that the medication would be delivered to them as a chemical restraint. While this comment does not address covert medication, it illustrates the spectrum of coercive strategies related to improving medication compliance.

SPEAKER: And if that doesn’t work then usually what happens is they are presented with the needle version of the medication and, interestingly enough, here, when I work here I’ve come across some patients that would rather take the needle than take it orally because – and their explanation – this is more than one patient that we’ve had who, like, they feel that they are, it’s being documented that they are refusing the medication. But a needle somehow is different to them. So, they’re almost more likely to consent to that. If that makes sense.
INTERVIEWER: So, they are consenting to the injection?
SPEAKER: Although they’re still refusing the medication in their point of view, they would rather get it as an injection and that is documented that security was called and stuff and that they were given the medication, so—

In the same way, another nurse-participant commented:

SPEAKER: So, so I don’t know if this medication is available in an injection…
INTERVIEWER: Uh huh.
SPEAKER:....like a depot or something like that.
INTERVIEWER: Okay.
SPEAKER: Um, I know some folks prefer that because they can have it once every couple of weeks, or once a week, and then they don't have to be reminded of it.
INTERVIEWER: Okay.
SPEAKER: And it’s also less medication, um, health care professional interaction.
INTERVIEWER: Okay.
SPEAKER: So, the health care professional interaction is more therapeutic in nature, versus about giving medication.

The participants in the focus group of legal experts also challenged the argument that covert medication is better than restraints.

And, then of course you wonder, like nowhere here does it really say why a refusal results in them putting medication in his food, right. Like, there is no clinical rationale for it. Like often, this is something you might see in the geriatric unit because they say, "Well, holding a frail person down in this scenario, they might be injured, you know, and you know it’s going to take down injecting them. So, it is so much more traumatizing then simply slipping it into their food.". Okay, fair enough. That’s how in some facilities, some of the tertiary care facilities, these covert medication policies got developed in the first place because they say it is much less traumatizing to hide, to carry out this rouse, hide medication and food, you know, tackle the person, inject them, each and every time he had to administer the medication. You have the same scenario they might be injured, they are frail they are vulnerable, but there is no attention paid to their psychological vulnerability, whether they are being supported in other ways. It is very layered from my perspective.

**III. RESEARCH QUESTION 3: WHAT ARE THE SOCIO-POLITICAL-LEGAL STRUCTURES UNDERLYING THE PRACTICE OF THE COVERT ADMINISTRATION OF MEDICATION TO ADULT INPATIENTS IN PSYCHIATRIC SETTINGS?**

Focus group and individual interview participants commented on the structures that underlie its practice. Some of the comments were general and are explored thematically here. In this analysis, I drew on critical legal studies and critical disability studies to emphasize the law’s structural and ideological influences, as set out in Chapter 2 (“Theoretical Frameworks”).
STRUCTURE: Construction and Maintenance of (In)Capacity

Some participants - especially the legal-participants- challenged the idea that capacity is an “either/or” construct. Those participants acknowledged the legal fiction: that there is a bright line between capacity and incapacity. This approach to global (in)capacity underlies the practice of the covert administration of medication. Staff may presume that a person does not have the capacity to participate in non-coercive interventions, like psycho-education, to improve treatment adherence.

Capacity is issue-specific, and a person may be capable of consenting to some treatment but not others. For instance, one legal participant commented on the second scenario where Chenglei’s capacity to make treatment decisions fluctuates:

Um, and so if the person is considered incapable that’s a global - it becomes a global incapacity, and then we start shifting around medications. I think the only place where people are drawing the lines, something like ECT, where they’re saying well that’s really qualitatively different than using medication. And because - for a lot of reasons we have to look at it differently. I think there are huge problems in fluctuating capacities, which means he’s capable a certain percentage of the time. Um, how is his capacity being supported in the first place? If he is capable?

If a patient is found to be incapable with respect to a decision about one medication, it is presumed that they are incapable with respect to all health care decisions. Below, the legal-participants speak about the second scenario:

SPKR_C: It also says that when he’s incapable, his father is his SDM, but I mean there’s no global - for all treatments -
SPKR_E: But how do we know that? Like, I think in practice - most of the time, in my experience, the doctors, at least in the tertiary care psych facilities are very seldom making these nuanced decisions respecting treatment. If you’re incapable of consent to treatment of a mental disorder, that’s it, that’s holus bolus. Every possible pharmacological approach imaginable and that, your illness, you’re not capable. […] But I think in practice, this isn’t happening, and I think there are probably instances where go to the Board with this and they’re not - they’re not looking for this kind of nuanced decision-making that you would expect.
There were general questions about the strength of the capacity assessment raised by the scenarios:

I mentioned the issue of capacity, right. So, there is a test for capacity and I do not know if someone is supposed to be really assessed for capacity when they are not being given a chance to assess the risks and benefits of the treatment that they are getting, because we do not know that they are getting it.

Some legal-participants also suggested that this approach produces and maintains incapacity. That is, if a patient incompetently complies with medication, an HCP will not challenge her capacity. However, if a patient resists medication, her capacity may then be questioned. In other words, a patient’s “compliance” with medication adherence determines the HCPs decision about capacity. One legal participant speaks about the first scenario where Manhor is determined to be incapable of making treatment decisions around the same time that he is moved to a psychiatric facility:

It also - - So what I find interesting in this scenario is that he has been treated for depression for many years ostensibly on his own consent. And complying and then it’s this move to the hospital where he is found incapable, but he seems upset the move, the way it is set out. Like, the way they set out. He is upset with the move, so he is consistently refusing medication. So, I would question the finding of incapacity.

This exchange between legal focus group participants illustrates the conflation of capacity and compliance. Here, the participants comment on the second of the three scenarios where Chenglei was found incapable of making a treatment decision to refuse Lithium. While admitted involuntarily, his father consented to Chenglei’s treatment with a new medication.

SPKR_G: Was he found incapable? I saw that he was admitted - but was he also found incapable?
INTERVIEWER: Yes.
SPKR_G: So he was found incapable - but incapable with respect to just the lithium. Presumably, so they had an obligation to ask him whether he would
have consented to try something new. Clearly, he didn't like the lithium because of the side effects. They could have just asked him. He may have been willing to take, we don't know - but he may have been willing to try something different. It doesn't appear that they even asked him if he would have tried the different medication. He could have been capable with respect to that.

[Crosstalk]

INTERVIEWER: He may not have been capable with respect to the lithium? He might have been capable with respect to valproic acid?

SPKR_G: Maybe

SPKR_B: Capable - or willing?

That conflation between capacity and compliance also applies to the SDM according to a participant from the legal group:

The other piece of this too is, if there’s an SDM that’s trying to assert the rights of the person they’re making decisions for, there is a good chance the doctor will try to get rid of that SDM and go to the next person. [...] Because what they’re looking for is compliance, with the proposed treatment, and there isn’t respect as there should be. Going from their college obligations forward there should be respect for the right to refuse. If you don’t feel, - it’s a decision that impacts you physiologically. If you don’t want to take that particular treatment there’s likely a good reason for it, it’s not all attributable to your inability to make a decision. These treatments carry many side effects, many risks, and they don’t have laser-point precision - correct? They’re very blunt instruments.

One nurse-participant in an individual interview described capacity as fluid, and able to be restored with medication (see Section “Recovery”, above).

SPEAKER: Yeah, the other part of it is – like, he’s not always incapable. Like he was incapable at the moment – so it just goes to – it just kind of goes to show that even if he had had, you know, maybe a week’s worth of treatment coercively, by that I mean like getting injections –

INTERVIEWER: Coercively.

SPEAKER: Yeah.

INTERVIEWER: Yeah.

SPEAKER: Then he could probably be able to make the decision himself to take oral form of the medication after, you know having that period of time where he wasn’t capable of someone kind of – I don’t know how to put it. You know what I mean? Like versus um – I’m not sure if I’m really explaining it right.
INTERVIEWER: No, this is great.
SPEAKER: ‘Cause, like in my experience people will be incapable at the beginning of their stay and then they become capable as they get more well to decide, "I want to take medication". ‘Cause they’re not that way the entire admission, ‘cause they’re better at the end.

This all-or-nothing approach to determining capacity was distinguished from an approach that imagined capacity as being able to be fostered. This alternative approach to determining capacity would be nuanced, nimble and responsive. In particular, legal-participants emphasized the benefits of a supported decision-making approach to capacity. Rather than finding a person to be either capable or incapable, a person is given assistance to make her own decision under a supported decision-making model.

SPKR_G: Okay. I think it also speaks to the limits of the HCCA, around consent. You know, are they capable or not capable, as opposed to some middle ground supported decision where you can actually try and work with the person to figure out what they want. [inaudible]
SPKR_D: I’d like to do his capacity hearing. [Crosstalk] [Laughter]

STRUCTURE: Stigma and Marginalization

Stigma, stereotypes and marginalization underlie the practice of covert medication. The decision to covertly administer medication may also be driven by stereotypes about persons with capacity issues or those viewed as wholly-incapable. For instance, participants in the legal focus group commented on the invisibility of the practice of covert medication as reflective of the experience of marginalization by persons with mental health issues.

SPKR_D: Exactly, you do not have consent so it is assault. With an incapable person, you have substitute consent, so you can treat, but do you have to tell the person that you’re tr...? I mean, I think it is ideal that you would, but would be liable for assault. I don’t know.
SPKR_B: That is what I was going to ask. I do not know if this is digressing or on point, but are there cases? But like, have people been charged with assault or...?
SPKR_C: For covert medication? I don’t think so.
SPKR_E: Well, you have to consider the population of the people that is
affected by this, and I think that in many instances those people are a
marginalized group of people who have enough trouble exercising their
most fundamental rights. And, trying to take action on this level is so much
more difficult without any kind of support.

Another nurse-participant in an individual interview raised concerns about lying to
patients in psychiatric settings, given their experience of stigma.

Yeah, I just don’t – I can’t imagine – I don't know. And then there’s so many
things about concealing stuff, in like food and drink, ‘cause like – you would
just be like lying. You're lying to somebody, you're being deceitful. It just
adds so much stigma to already such a stigmatized area.

On the other hand, one nurse-participant raised the stigma associated with mental
illness as justifying the covert administration of medication. That is, persons with mental
health issues may need medication support to remain well in the community.

We are not tolerant of mental illness, and we are just touching that surface
of the people that are demented. We are not set up for them, and if we don't
medicate them somehow, in the most humane way possible, where are we
going to store them all? Because there is nowhere for them to go until their
behaviour is manageable, and they can do all kinds of terrible things.

The three scenarios included diverse inpatients: older adults, women and persons of
colour. However, most participants did not comment on the influence of the patients’
socio-cultural locations on the decision to covertly medicate. One psychiatrist
participant comments on the first scenario, where Manhor's wife administers medication
in his tea while he is at home:

I’d also want to like, explore culturally, um, what their expectations are
around treatment. Like, I don't know where Manhor is from, but who knows
what his understanding is of mental illness and treatment, and whether
covered treatment is just the way they do it?

**STRUCTURE: Dementia is a Whole New Ballgame**
Participants often raised the frequency of the practice in geriatric psychiatry settings. One nurse-participant in an individual interview pointed out that she had encountered the practice in the geriatric ward:

This topic, primarily, is something that comes to mind when I think of geriatrics psychiatry more-so than other areas.

The nurse-participants in the focus group also commented on the frequency of the practice in geriatric psychiatric units:

INTERVIEWER: How common is that practice of putting it in food when I think you said when someone is demented?
SPKR_A: When someone is demented, then quite often.

One nurse participant in an individual interview considered barriers to medication administration as set out by the third scenario where a patient has a history of dementia-related psychosis:

Hm. It’s interesting that she just doesn’t like the Olanzapine. ’Cause she was taking the Seroquel. Again, I’d ask her why she doesn’t want to take it. Um – yeah. It says she’s – hmm. Yeah. I just wonder why – like I wonder why she doesn’t want to take it. Like if she’s having psychotic symptoms, she might be very paranoid and you know, the colour of the pill or, you know, that effect, it’s different.

Another physician-participant pointed out that crushing pills in cases where a geriatric patient has a swallowing problem raises similar issues:

SPKR_E: Like, if you’re not doing it surreptitiously, if you’re crushing it and putting it in applesauce because they have swallowing problems, or something like that, I think that’s covered by the consent, just for oral. But, if you’re doing it surreptitiously, I see that as being a different enough intervention that you’d be compelled to get -- you have to explain that to the substitute, and include that.
INTERVIEWER: Okay.
SPKR_D: And, in this case, the person is demented, right? So, I don’t even know if asking them would fly.
SPKR_C: Huh? Sorry? [Laughter]
SPKR_D: If you were like, “Well we're just going to crush it and put it in your food,” and just -- like, how do we know that they even understand that 100%?
INTERVIEWER: Oh, right.
SPKR_D: So, I don’t think that would fly.

Another nurse-participant continued on to describe the practice where a person has dementia as a “whole new ballgame”.508 During a discussion of the third scenario, including about the practice’s impact on therapeutic relationships, the nurse-participants considered the value of health teaching after the covert administration of medication:

SPKR_B: For me, this is a totally different because she has got dementia. So, it is very difficult, depending on where along the dementia scale she is, depending where she is, how demented this patient is. But to attempt to health teach, or – – I mean we do it anyway, absolutely. You know, "You are feeling better because you have been taking the medication." "You are calmer," whatever. Whether that is going to, you know, she is going to understand and then process it and be able to reason is another story. But, of course, you do that.

The nurse-participants in the focus group also raised barriers to medication administration for patients with dementia:

SPKR_C: The other thing is, you don’t want to fight with a woman who has dementia. For what? You don’t want to get into a power struggle with meds. I think it just agitates people unnecessarily. [Crosstalk]
SPKR_A: You want them to be calm as possible and low-key. That's your whole approach is quiet, gentle, slow, you know, one task at a time.
INTERVIEWER: So fighting over medication..
SPKR_A: ...is counter therapeutic. [Crosstalk]
SPKR_C: Good word.
SPKR_B: What is interesting though, and this is even with patients with dementia, is depending on how well they know and trust they have

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508 One nurse-participant in the focus group first put it this way: “I'm going to do what I can to get it into them, but I am not going to lie to them. Dementia is a whole new ball game. A whole new ballgame because they don't have that capacity.” The same participant used the term again later: “Dementia is a whole different ballgame than any other mental health issues.”
developed with a specific staff member, they may take the medications from PARTICIPANT NAME, but not from me. Or, from me, but not from her.

About the third scenario, a nurse-participant in an individual interview offered her thoughts as to why the practice differs in geriatric psychiatric unit, in comparison to other inpatient units. She appeared to suggest that it was easier to justify the practice if a patient had dementia.

It’s really mostly geriatric psychiatry that I’ve seen it. Maybe others would say alternatively, but – um, sometimes I find in geriatric psychiatry is, like, maintaining someone’s dignity. Like, they’ve lived a long and respectable life, usually, and they’ve – now they’re taking their clothes off in front of people or they’re now, you know, incontinent in front of their peers, or—. You know, it’s really embarrassing [...] and horrible things. And, and they are sometimes hurting themselves and you know if you – like, again, it’s done under really good intent. [...] Um, and I, I don’t have as much of – like, if someone asked me about my own mother in that scenario, about hiding it in her jam or whatever that might be, I would be completely fine with it if I felt that it was making her able to be more herself, less agitated, not hurting herself, not taking her clothes off, you know, in front of other – just all these sorts of really not so lovely symptoms that people have.

STRUCTURE: Barriers to Team-Based Decision-Making

Deference to medical decision-making underlies the practice of covert medication. In the focus group and individual interviews, there was some commentary about the influence of team culture on medication administration in psychiatric settings.

Given the lack of policies and guidelines, it is not clear that all HCP team members (including social workers, nurses or pharmacists) must consent before a covert medication plan is implemented. Some participants commented on HCPs’ professional obligations including the right to refuse to carry out an order to covertly medicate a patient where, for example, a nurse disagrees with a decision about medication administration:

Yeah. You know, and as a nurse you need to – just because a doctor orders it
doesn't mean you have to follow through with it. If you don't feel comfortable doing it you should not be doing it. Yeah. Like if someone ordered it I'd be like, I'm not doing that.

Another nurse-participant raised questions, in an individual interview, about the importance of a team-based approach to decision-making about medication administration. While she did not expressly raise concerns about the barriers to that teamwork, she points out that the decisions of the team must be well documented.

One thing that comes to mind when I read this [...] is that, um, shouldn't the order say, not just for the valproic acid but the valproic acid to be administered orally in the juice, like, like, to be clear about that, if that's the order. Um, like, I, absolutely that it can be – I just have a— [...] I can just – I have a feeling that if anything were to come out of this from a, a legal perspective [...] that a physician would then be, like, “Well, I ordered it orally. It was the nurses that made it, put it and hid it into the client’s, um, juice” [...] So, if a team decision’s made, like it has to be well documented and then... including the substitute decision maker. I don't know if they have to sign off on something saying, like, this is what we've decided as a, a treatment plan[...] and also, there's all this – this isn't like Nurse A says it's okay to be put in the juice, and then Nurse B hasn't really been communicated with it well, and Nurse B has an issue with that because she doesn't believe in that. And then Nurse C thinks, “Well, Nurse A did it, so I can do whatever I want”. Like, so it's [...] communication in health care is a huge issue in itself.

**STRUCTURE: Medicalization**

Deference to medical knowledge among health teams, above, may contribute to the feeling, expressed by some participants, that medication is the only viable treatment “on the menu”. Participants commented on the emphasis that the practice places on medication and its presumption of medication’s efficacy. That is, the decision to covertly administer medication relies on a faith that medication will assist the patients. As expressed by one legal group participant, the practice emphasizes the importance of getting medication into a patient:

SPKR_E: Also, I think it also touches on the mythology that is attached to
medication and what the gain is going to be clinically. Just simply, all you need to do is get the person to take the medication. Nothing else needs to be done, and he or she will be better. Which is, a wish, if you will, or a dream, - myth, and a lot of the decision-making I think where people are torn, or SDM's are wrestling with whether to give consent and weighing the pros and cons. I think a lot of their willingness to do this rests on "the doctors right" and "it's for the person's own good". They're not really specifically weighing the pros and cons and risks and benefits, They're more following suit with the treatment team. So, you lose all those nuances in terms of someone's treatment plan. There are many other dimensions to a treatment plan. - he’s admitted to hospital, what is he doing in hospital? If he’s not taking medication, what is he doing? Because most facilities don't have real programming, outside of medication management. So, what's his - what is his conceptualization of his being hospitalized? Like, he probably has no idea.

SPKR_C: He doesn't think that he is being treated either. I'm having a nice cup of tea. [Crosstalk].

Another legal-participant elaborated on this point:

And um, everything hinges on the medication, I think it’s a very simplistic way of - it’s just, it seems to be bad clinical practice, aside from everything else that’s going on

Faith in medication appears to come from deference to medical decision-making (See “Structures: Barriers to Team-Based Decision Making” above). The exchange below, between psychiatrist-participants, is illustrative:

SPKR_A: Most people just want their family member or loved one to get better, and they're like, “You're the doctor,” you know? Like, it's funny though, sometimes you're like, “Why are you asking me these questions?”. Like, don’t you, like --
SPKR_E: Yeah, “You tell me what to do.”
SPKR_A: -- and then the families are really amazed sometimes, that, like, people are, like, admitted to hospital, acute care facility, and like, they're here for two weeks without treatment. And they're, like, shocked that that’s even possible.
Another example of the deference to medical decision-making that underlies the practice of covert medication includes SDMs’ deference to the HCP, as expressed by one legal focus group participant:

My guess is that the wife has simply been told by the doctor, he needs this medication, it’s really good for him, and how can we get him to take it, right? She's not questioning.

About one scenario, a nurse-participant challenged the decision of the HCP to not tell the patient about covert administration of medication on discharge. In this excerpt, the nurse-participant considers the second scenario in which Chenglei discovers the fact of the covert medication after discharge from hospital.

INTERVIEWER: Are you saying then that this situation could have been avoided if ... there was an alternative to this – – to the way things went? Um, because he could have been, Chenglei could have been told about the meds and that could have assisted him [cross talking] – –
SPKR_C: Should have been, not could have been. That was the first thing when I read it. I thought, “stupid psychiatrists...you got what you deserved”.
[laughter]
INTERVIEWER: Right.
SPKR_C: It is incumbent on them to do that kind of teaching.
INTERVIEWER: Is there – – are you saying then it could have assisted Chenglei to make a capable decision later, or [cross talking]?
SPKR_C: He’s so sick he probably wouldn't, but they would have to go through it again each time if like, "we had to do it again sweetheart because you are so sick. Look how good you are now."

STRUCTURE: Institutional Risk and Liability

Questions were raised about institutional responsibility for the development and implementation of policies about the covert administration of medication. In fact, participants were generally not aware of policies at their institution. While there are unanswered questions about the responsibility of HCPs concerning covert medication (see “HCP: Access to Information” above), confusion and silence underlies and reinforces the practice. Covert practices flourish without oversight or accountability.
One participant in an individual interview presumed that psychiatric settings must have policies about the practice. However, the document analysis revealed that very few psychiatric settings have policies that expressly govern the practice.

INTERVIEWER: Yeah. Mm-hmm. Are there any, do you think that there are any laws, policies or practice guidelines that the nurses could have drawn on? Are there legal implications that – of the issues that arise in this scenario?
SPEAKER: I’m not too sure, to be honest. I’m not very, not too aware of those things. There are probably local policies, like, hospital, whatever…
INTERVIEWER: Local policies?
SPEAKER: …they, they must have policies around this at their workplace, so—
INTERVIEWER: Policies about?
SPEAKER: Medication administration and what happens, like, is this something ethical? Or, I guess, I would – this isn’t really policies but maybe I would consult the advance practice nurse and the nurse educator for that unit to see, like, to get their feedback and, because part of their job is also, like, to come up with care plans and stuff or a challenging scenario and I think this would qualify. And I’m sure they would be better versed in the policies and procedures…

There were unanswered questions about the liability of institutions and HCPs who covertly medicate patients. This exchange between psychiatrists in the focus group is illustrative:

SPKR_D: And, with laws are you talking about, like, assault? Are you talking about charges?
INTERVIEWER: We’re talking about all of it, I guess, yeah.
SPKR_D: So I guess, our worst case, I think, you know, is “did I assault this patient?”
SPKR_E: Or even battery is technically the charge.
SPKR_D: Battery?
SPKR_E: Yeah.
SPKR_D: Okay. Well, maybe, yeah. It’s not quite an assault.
SPKR_B: Depends on the size of the needle -- 14 gauge… [Laughter]
These institutional silences are confusing and uncomfortable. Although it was not obvious in the transcripts of the interviews, participants appeared uncomfortable with the silences that surround the practice.

I hope not. Yeah, no, I will, I want – it makes me realize that there's so many unknowns [...] and that's, I think, one of the vulnerabilities about being within a health care profession, is that, um, not only from a legal perspective but you can’t, you can't know everything so you're trying to make the best decision based on what you know in the moment [...] with the patient's, um, best interests in mind, knowing that sometimes you don't always know what their best interests are because they come in really ill. [...] So, you're trying to make that judgment and, and obviously this person has a substitute decision maker so keeping Nadira's, everything that you do, you've kind of got her voice in the back of your mind.

There were additional questions about the liability of institutions and HCPs who fail to covertly medicate. That is, participants considered whether the failure to covertly medicate could amount to a breach of their duty of care. This concern was expressed by one nurse-participant:

SPKR_B: So, if you are deemed incapable, and there is a substitute decision-maker and it is all legally in place, yeah, then you have to get the medications into, them.
INTERVIEWER: Can you say that again? So, if the SDM consents and the person is incapable then you have to get the medication into them.
SPKR_B: Right.

A nurse in an individual interview stressed the responsibility of organizations to support HCPs:

SPEAKER: As well as from an organizational standpoint. So, I think sometimes there’s a lot that’s put on individual practitioners, um, and I think organizations should be supporting and not just backing them up when something goes wrong but supporting them up front and saying, um, we need to have some of these, like, this training for our substitute decision makers of this information. Um, maybe there’s a nice little package that guides the conversation that needs to happen, that the organization develops.
INTERVIEWER: Mm-hmm. There should be guidance from the organization.
SPEAKER: Yeah. Absolutely.

One psychiatrist-participant raised questions about the influence of considerations of the safety of other patients or staff. The decision to covertly medicate should consider the failure to medicate on the safety of other patients and staff.

SPKR_A: So, if Cheng-li’s manic on the ward, and he’s threatening, or agitated, and is, like, putting his safety at risk, or safety of patients or staff [...] -- then he’ll get a chemical restraint to alter that behaviour [...] which is the similar medication that would have been administered as a treatment that’s not the indication for which we’re giving it.

INTERVIEWER: Right. And, in that case, consent is not required?
SPKR_A: No consent required.

Participants in the nurses’ focus group commented on the right of patients to refuse medication, except when there are “safety” issues:

SPKR_B: And then, but if their behavior is a danger to themselves or others then we have to look at the safety issue, and then that same medication will often be administered by injection.

INTERVIEWER: So, if they refused by mouth and--
SPKR_C: And, there is behavioural issues, or safety issues—[crosstalk]
SPKR_C: It depends on their clinical presentation at that time.

INTERVIEWER: Okay.
SPKR_C: So, if someone is acting out, if they are a danger to others around them, or to themselves, if they are violent, if they are beating up on themselves...

Though not a data point from the document analysis or the focus groups /individual interviews, one the most striking findings was an apparent reluctance to discuss the practice openly. For instance, there were barriers to the disclosure of institutional policies and practice guidelines that govern the covert administration of administration. Securing access to those documents from two psychiatric settings required multiple administrative steps, as outlined in Appendix F (“Timeline – Freedom of Information Requests”).
STRUCTURE: A Problem of Governance

Participants considered the willingness of HCPs, SDMs and institutions to give life to the law. While there are rights articulated in legislation, including the *Health Care Consent Act*, there are different questions about the will to implement them. In the legal literature, this is described as the difference between law-on-the-books and law-in-action.

Covert medication is an example of a controversial practice that creates confusion and institutional silence. For such practices, the law is difficult to apply, or there is a reluctance to figure out how to apply legal protections. A participant in the focus group of legal experts made this comment about the willingness to give life to the law:

"Right? Like I mean, the system is set up to be very - there was a revolution in giving patients more autonomy, but in practice -"

In the same focus group, a legal expert made this comment:

"From my perspective, my experience in our office and working in these specialty hospitals, the rights that people have - and you look at the legislation - it’s reasonably well written, but people never realize their rights. You think of the legal framework as sort of being the short end of the stick, you know, this is the boundary. But it’s not. Can anybody here tell me, has a Section 80 charge ever been successful laid against anybody in the system, you know. It sits there as a protection, but there is no recourse. No one has ever successfully laid a Section 80 charge against any health care provider. Yet, we know from experience that people’s rights are violated every single day. It’s not that hard to follow the HCCA if you have the will to do that, right. It’s not that difficult, it’s not that onerous a thing to engage people, and to ask for consent and get an informed consent from the SDM."

Another legal-participant described the physician’s obligation to ensure that the SDM has enough information to make an informed decision to covertly medicate a patient. In particular, the participant wondered whether the patient would have access to counsel or advocacy to make sure that informed consent was given:
Again, you know, these are empty – no rights without remedy kind of thing.

The participants in the legal focus group, referring to a recent dispute between the Prime Minister of Canada and another politician about amendments to the *Criminal Code*, commented:

SPKR_B: INTERVIEWER I know you're talking to um, other groups of people about these. But it seems to me, like so many other complex legal problems. Law is really - like you only ever start talking about legal rights when everything else is broken down, right. And so the real problems here are not legal at all, but just, you know a lack of respect and an under-resourced system where people are too busy to sit down and do things properly.

SPKR_C: Sometimes - sorry, not to defend the hospitals and their practices -

SPKR_B: No, no -

SPKR_C: But, sometimes the SDM's in long-term care, you know

SPKR_B: You've got to do it.

SPKR_C: And sometimes they cave to it, right? Even if they didn't suggest it, but sometimes they do suggest it themselves, so it's -

SPKR_B: Yeah, so it seems to me, solutions to me that so many of these problems come much earlier, and it's like the Justin Trudeau/Stephen Harper dispute, you know you just get mocked for saying we want to get to the root cause, let's just get the bad guys in jail, you know? Where - but anyway, that's just what is calling out to me. None of this - you know, why didn't we solve these problems before? And so maybe a focus on legal issues earlier on, you know.

IV. ESTABLISHING THE DATA’S TRUSTWORTHINESS

This research relied on three strategies to improve its validity: pilot studies, negative case analysis and reflexive accounting. Relying on Elliot and Timulak (2005), validity was continually assessed throughout all stages of the research. This section details the results of these three strategies.

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Elliot & Timulak (2005), *supra* note 477 at 156.
i) Pilot Studies

This pilot-study checked for threats to internal validity, including the flow of questions in the topic guide, unbiased wording, understandable terms and the use of jargon. The pilot ensured that the three clinical scenarios made clinical sense, were diverse enough and likely to result in an adequate range of responses. This pilot study informed the development of the semi-structured interview and scenarios. The second pilot study improved the internal validity of the semi-structured interview and the clinical scenarios.

During the pilot studies, the researcher discovered what it felt like to talk about medication administration, including using the “lingo” of medication administration. During the pilot interviews, the researcher honed interviewing skills, including the use of value free language (“I'm interested in learning more about the practice...”). By attending to trust and rapport, the researcher was more likely to describe the practice of covert medication accurately. Without this, participants might have perceived the research as appearing to blame particular stakeholders. The pilot studies offered an opportunity to practice talking about a controversial subject in a supportive way, which helped achieve buy-in.

ii) Negative Case Analysis

Throughout all phases of the research and especially during coding, the researcher prepared analytic memos. During the development of analytic memos, the researcher aimed to be alert to possibly disconfirming evidence or negative cases. For instance, most participants addressed the impact of covert medication on how a patient recovers. However, there was split response here. Some participants characterized covert medication as “autonomy restoring” since it assists a person to make her own decision after a few hidden doses. On the other hand, some participants commented on potential impacts on a person’s long-term prospects for “real” recovery. If the patient does not
know about the covert medication as she transfers from the inpatient unit, it may be
difficult for her to remain well within the community.

Possibly disconfirming (or at least confusing) evidence was also flagged during coding
for the "best interests" theme. Participants raised "best interests" arguments to support,
reject or qualify the practice. These questions were raised in many forms. The theme was
the most diverse and most difficult to conceptualize. Some participants thought that
covert medication may be in a patient's best interests since it was better than restraining
and injecting a patient. Others thought that it was in a patient's 'best interest' to allow for
capable refusal of medication. The researcher returned to the data many times to try to
pull at the edges of the definition of "best interests."

Ultimately, these two examples were not characterized as "negative cases" or
disconfirming evidence. Rather, the messiness of these codes was evidence of their
richness. While participants' various understandings of "recovery" and "best interests"
were difficult to distinguish and tease apart, they were not necessarily contradictory.
The concepts' definitional breadth may speak to tensions between different approaches
to the delivery of mental health services and supports. The apparent contradictions
may also highlight the key importance of attention to context. The determination of the
application of "recovery" and "best interests" may depend on a particular patient's
situation.

iii) Reflexive Accounting

In this section, I return to the use of the first person pronoun, as I did in Chapter 5
("Methods and Methodology"). To be forthcoming about my own influence on the data, I
adopted a self-critical approach. Rather than hide or negate my own attitudes towards

510 See, for example, Jijian Voronka, Deborah Wise Harris, Jill Grant, Janina Komaroff, Dawn Boyle &
Arianna Kennedy, “Un/Helpful Help and Its Discontents: Peer Researchers Paying Attention to Street Life
Narratives to Inform Social Work Policy and Practice” (2014) 12:3 Social Work in Mental Health 249 at
251ff.
the data, I strived to be honest about how my positionality constructed the data.\textsuperscript{511} I have multiple subjectivities that are relevant to the subject of covert administration of medication. I am a lawyer who has practiced in the area of disability rights and has represented persons with mental health issues. I am the family member of someone with personal experience of the mental health system. Also, I used to work at the Centre for Addiction and Mental Health (CAMH). After working at CAMH, I went to law school where I started to frame mental health as, at least in part, a rights issue (rather than the sole concern of the psychiatric system).

My various experiences have not led me to a clear understanding of the covert administration of medication. Typically, family members of persons with mental health issues advocate for ways to make it easier for persons with mental health issues to access medications. On the other hand, lawyers may be primarily concerned with deprivations of rights, as conceived of by dominant understanding of autonomy. Indeed, I feel conflicted by the practice. I do, however, have a “gut feeling” that the practice should be subjected to exploration, examination and debate.

As I developed reflexive memos as described in Chapter 5 ("Methods and Methodology"), I understood that it was difficult to be alert to how my socio-cultural locations influenced the data analysis. For instance, the naming of themes unwittingly reflected my own position. I worded some themes negatively ("freedom from abuse") and others more positively ("right to participate in decision making"). I found myself returning to the use of the phrase: “a person subject to covert medication.”

\textsuperscript{511} Schram (2003), \textit{supra} note 485 at 32: “Assumptions are also at work to influence the particular way you like at society and social phenomena. Once again, making these assumptions explicit is important for understanding, and making clear to other, why you attend to some thing but not to others in the conduct of your inquiry.”
V. SUMMARY OF FINDINGS

There were few institutional policies, clinical protocols or practice guidelines that applied to the covert administration of medication. According to the two available policies, the practice is only considered for patients who are incapable of giving consent and the SDM must explicitly consent to the concealment. There were additional questions about the professional responsibility of HCPs involved in the covert administration of medication.

The research addressed the practice’s impact on patients’ rights experience. The practice impairs access to knowledge by patients, SDMs and HCPs. In particular, covert medication precludes the patient from participating in treatment decision-making. The practice interferes with the therapeutic relationships. Covert medication determines how a patient recovers. Some participants characterized covert medication as “autonomy restoring” in that it assists someone to make their own decisions after a few doses. On the other hand, some participants commented on the impact of the practice on a person’s long-term prospects for “real” recovery as they transfer from the inpatient unit to the community. Covert medication interferes with patient focus and engagement since it excludes the patient’s perspective, including underlying reasons for refusing medication and the presence of unwanted side effects. Many questions were raised about how the practice impacts patients' best interests.

This research also explored the structures that underlie the practice. The practice in psycho-geriatric units is different than its practice in other units. An understanding of capacity - as an “either/or” construct, - underlies the practice. This all-or-nothing approach to determining capacity was distinguished from an approach that imagined capacity as able to be fostered with support. The decision to covertly administer medication may be driven by stereotypes about persons with capacity issues. The invisibility of the practice of covert medication is reflective of the experience of marginalization by persons with mental health issues. A team culture that defers to medical-decisioning underlies the practice of covert medication. By emphasizing the
importance of medication, the practice of the covert administration of medication relies on a faith that medication will be effective. Confusion and institutional silences underlie and reinforce the practice. In fact, participants were not aware of the policies at their institution, and there are unanswered questions about the responsibility of HCPs, SDMs and institutions.
FIGURE 1: CONCEPTUAL MAP

Underlying Socio-Political-Legal Structures

Construction and Maintenance of Incapacity: conflation of capacity and compliance, all-or-nothing approach compared to “supported decision making models”

Stigma and Marginalization: incl. presumptions about the capacity to engage in non-coercive strategies

Dementia: incl. the practice in psycho-geriatric units

Barriers to Team-based Decisions: influence of team culture and medical dominance

Medicalization: everything hinges on the medication

Perceptions of Institutional Risk and Liability: fear, silence, confusion

Problem of Governance: willingness to give life to the law

Impact on Patients’ Rights Situation

Access to Knowledge: including information, support and education by Patients, SDM, and HCP

Trust and Truth: including willingness to seek help in the future

Recovery: assist someone to make capable decisions (after a few doses) but also make transition to the community difficult

Best Interests: covert medication is generally seen to be better than restraints, but some patients prefer injections.

COVERT ADMINISTRATION OF MEDICATION in psychiatric settings to patients determined to be incapable of making treatment decisions
CHAPTER 7: DISCUSSION

This chapter offers integrative interpretations of the data described in Chapter 6 ("Results"). It aims to “tell the story” and “bring meaning and coherence to the themes, patterns and categories, developing linkages and a story line that makes sense.”\textsuperscript{512} It draws on academic literature, related to covert medication, as well as on the researcher’s personal experiences of “doing” the research. This chapter is divided into three sections that support the following conclusions:

1. Covert medication is contextually driven. It is an incident of and maintained by the larger psychiatric system.
2. Covert medication reflects an inflexible approach to the determination of treatment incapacity and is primarily concerned with the management of “risky” inpatients in the short-term.
3. Covert medication is an example of law’s indeterminacy to a complex and under-scrutinized question in Ontario.

During analysis, the research questions were difficult to separate. For instance, law’s indeterminacy both drives and maintains the practice (Question 3) and also impacts patients’ “rights” experience (Question 2). As a result, this chapter weaves together a discussion of the three research questions.

1. What are the common themes of institutional policies, clinical protocols or practice guidelines that apply directly or indirectly to the covert administration of medication?
2. What is the understanding of (1) legal experts, including patient advocates and ex-patient advocates, (2) nurses with inpatient psychiatric nursing experience, (3) and psychiatrists on the impact of covert administration to the rights-

\textsuperscript{512} Marshall & Rossman (2010), supra note 170 at 219.
situation of incapable adult inpatients in psychiatric settings?

3. What are the socio-political-legal structures underlying the practice of the covert administration of medication to adult inpatients in psychiatric settings?

This research relied on a rights-based approach to explore the practice of the covert administration of medication in psychiatric settings. Rather than perceived as requiring assistance or charity, a person is conceived of as a rights-bearer. A rights-based analysis also has a procedural dimension; it includes consideration of a patient’s access to meaningful accountability mechanisms. Detailed in Chapter 2 (“Theoretical Framework”), the Law Commission of Ontario’s (LCO) Framework for the Law As It Affects Persons with Disabilities identified six principles to understand how laws, policies and practices impact persons with disabilities.

This research also relied on critical approaches to the law, focusing particular attention to how those rights are expressed. The research went beyond an enumeration of different takes on the controversial practice. Instead, it aimed to understand and contextualize the meaning of rights in psychiatric settings, especially in an on-the-ground sense. To do this, critical theories were used to emphasize the law’s indeterminacy and to interrogate the complex power relationships at play in the covert administration of medication.

I. THE CONTEXT OF COVERT MEDICATION

This Section considers how covert medication fits within psychiatric practice. While covert medication may be an exceptional practice, it is an incident of and cannot be divorced from the larger psychiatric system(s). Grounded in public health, this research relied on a broad understanding of the practice rather than focusing on individual HCP-

513 World Health Organization (WHO), Human Rights-Based Approach to Health, online: WHO <www.who.int/trade/glossary/story054/en/>: “Integrating human rights into development also means empowering poor people, ensuring their participation in decision-making processes which concern them and incorporating accountability mechanisms which they can access.”

514 LCO Framework (2012), supra note 63.
patient interactions. This research also relied on an interdisciplinary approach, drawing upon the fields of public health, bioethics, nursing, law and the sociology of law. Such combined attention refocused attention on the contexts of the health and wellbeing of marginalized populations.

i) Constraining Choice

The literature described covert medication as commonplace in long-term care settings. There is little data from psychiatric settings, though nurse and psychiatrist participants described the practice of covert medication as extraordinary. None of the legal participants had encountered the practice of covert medication in a psychiatric setting. Nevertheless, interview and focus group participants emphasized that covert medication is not an anomalous practice.

One legal-participant described covert medication as belonging to a “spectrum” of coercive practices. Participants offered examples of practices that constrain choices. These strategies vary in how passive or active they are in terms of patient involvement.

• For example, an HCP might offer rewards or inducements, like increased social activities, cigarettes and financial incentives to a patient if she takes her medication. In such cases, the patient is engaged in the medication decision, albeit with limited choices presented to her.
• Several participants, including from the psychiatrist focus group, described strategies to ensure medication compliance, like advising patients that they have to take their medications, but that it was up to them as to how they were going to take it. HCPs tell patients that unless they take the medication on their own, they

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515 Haw & Stubbs (2010), supra note 344; Kirkevold & Engedal (2005), supra note 357; Treloar, Beats & Philpot (2000), supra note 364; Stubbs, Haw & Dickens (2008), supra note 20 at 618.
516 Bock, Sales, Rogers & DeVoe (2001), supra note 2.
517 Pereira, Beer & Paton (1999), supra note 3.
will get the same medication as a chemical restraint by injection. The patient is aware of the very limited choices presented to her.

• In some cases, an HCP may physically restrain a person and deliver the medication by intramuscular injection or suppository, as a chemical restraint. A choice is not presented to the patient, but she is aware of the fact of the chemical restraint. Two nurse-participants suggested that some patients prefer chemical restraints, since the administration was documented.

• One nurse-participant also described leaving juice mixed with medication at the patient's bedside. In these cases, the patient has no information with which to make a choice to refuse or consent to treatment.

• Another nurse-participant described a “role-playing” strategy to encourage medication compliance. Nurses speak to each other in front of the patient about the benefits of a medication without the patient knowing that the nurses intended for the patient to overhear the conversation. In his way, information is provided to the patient, but under false pretenses.

• One participant in the focus group of nurses described telling a patient determined to be incapable of making treatment decisions that medications were “vitamins” or “Tylenol” in order to encourage medication compliance. Here, false information is provided to the patient.

The covert administration of medication is also a strategy - of a larger toolbox - to encourage medication compliance. Covert medication and other strategies raised by participants all limit or constrain choices available to patients who resist medication. While the language of consumer choice has enjoyed recent prominence in mental health policy, there are questions about its on-the-ground utility. The section (“Recovery

520 Chiara Samele, Simon Lawton-Smith, Lesley Warner & Jeevi Maristhasan, "Patient Choice in Psychiatry" (2007) 191 BJP 1: “In Australia, New Zealand and Canada, a range of mental health plans, strategies and guidance refers to the importance of choice, sometimes using the language of consumer participation [...] However, in practice, choice is commonly not available. This might arise from health professionals' reluctance to offer choices or through limitations on available services, primarily as a result of financial constraints both on services and on patients.”
Focussed and Patient-Centered”), below, offers additional comment on the value of recovery-focused and patient-centered approaches that emphasise patient choice.

ii) Barriers to Medication Administration

Systematic and contextual factors may drive the decision to covertly medicate. Commentators have identified various factors, in this regard, including pressures to maintain control of a busy psychiatric unit without adequate resources, unclear and/or conflicting professional responsibilities, or the inaccessibility of policies that govern the practice. Lewin (2005) found that some health care providers use covert administration to avoid treatment delays. While few participants directly considered the reasons that underlie the practice, these examples from the literature are consistent with focus group and interview data.

Participants commented on the barriers that HCPs face delivering medication to adult inpatients. The patient’s refusal is an obvious barrier to medication delivery. In their literature review, Owiti and Bowers (2010) classified the various ways that patients may refuse medication, including pretending to be asleep. Described as the “covert refusal

\[521\text{ Lyn & Rios (2006), supra note 16 at 478: “In a time when ED resources are limited, the desire for some emergency physicians to use covert medication in order to subdue agitated patients illustrated the need for more supportive resources in the ED setting.” See also Welsh & Deahl (2002), supra note 14 at 124 “Arguably, in residential settings, tranquilizing medication might be seen as a cheap means of managing inadequate staffing level (and thus ensuring a quiet shift) or an essential (and least restrictive?) means of managing unpredictable, violent outbursts against staff and fellow patients.”}

\[522\text{ Kellet (1996), supra note 369.}

\[523\text{ Wong, Poon & Hui (2005), supra note 18 at 262: “...it may become an “easy excuse” for not discussing and explaining treatment to patients or their families, and may also reinforce tolerance of poor staffing levels or poor standards in patient care settings. These risks are amplified when the practice remains unregulated and unmonitored because of a lack of legal or professional guidelines, and of the secrecy surrounding the practice due to fear of professional censure.”}

\[524\text{ Lewin, Montauk, Shalit & Nobay (2006), supra note 18.}

\[525\text{ Owiti & Bowers (2010), supra note 80: “In the literature reviewed, various terminologies have been used to refer to patients that refuse medication, such as non-complier, very non-complier, consistent refuser, non-consistent refuser, persistent refuser and non-persistent refuser.”}
of medication”, patients may “cheek” or “tongue” medication, pretending to take it but hiding it in their mouth.526

Medication refusal can be understood as a public health issue since, as reported by Morken and others (2008), non-adherence to antipsychotic medication to community-based outpatients is associated with relapses and hospital admissions.527 Similarly, improving medication adherence might be considered a public health intervention for psychiatric inpatients. Medication refusal is common in psychiatric settings. In their recent systematic literature review, Higashi and others (2013) found that about half of all people do not adhere to prescribed antipsychotic medication.528 Owiti and Bowers (2010) emphasized that “[m]edication refusal is at the center of conflict and containment in psychiatry.”529 Nurse-participants in the focus group reported almost daily experience with medication refusal.

Another barrier to medication delivery is that HCPs do not understand reasons for treatment refusal, especially in patients with dementia. Some patients may appear to reject particular types of medication randomly. One nurse participant offered an example of a patient with dementia-related psychosis whose refusal of medication was based on the colour of the pill. Other times, a patient may agree to take medication from one nurse but not another. Nurse-participants in the focus group also pointed out that a patient with dementia may refuse medication at one time but agree to take the medication a few minutes later. Morrison and others (2012) asserted that people may refuse medication because of high levels of internalized stigma.530 At first glance, the refusal may appear to be random. These multiple factors may make it difficult to

526 Owiti & Bowers (2012), supra note 80.
527 Morken, Widen & Grawe (2008), supra note 79 at 32: “Non-adherence was associated with relapse, hospital admission and having persistent psychotic symptoms. Interventions to increase adherence are needed.”
528 Higashi, Medic, Littlewood, Diez, Granström & De Hert (2013), supra note 78.
529 Owiti & Bowers (2010), supra note 80 at 2.
determine why a patient refuses medication. In chaotic and crowded inpatient units, an HCP may not have the time or resources to engage with patients to determine underlying reasons for refusal.

Neurological conditions, strokes, salivary changes and psychological illness can lead to trouble swallowing pills. Dysphagia may be prevalent for older inpatients, like those in geriatric units, and is common among residents living in long-term care facilities. Kelly, DaCruz and Wright (2009) found that managing medication for patients with dysphagia by crushing tablets in food may “lead” to covert medication, since the patient may not be aware that her food contains medication.

In Ontario, the last forty years have seen the closure of major psychiatric institutions. Despite the promise of deinstitutionalization, community-based services remain under-funded and over-subscribed. Following deinstitutionalization, inpatient units in Ontario were understaffed and community-based supports were under-resourced. Kilty (2008) asserted that, following deinstitutionalization, people with mental health issues were “readmitted into state care but into the criminal justice system then than the mental health system.” Gable and Gostin (2009) posited that deinstitutionalization has led to an “explosion in the number of mentally disabled people who have become

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532 Jennifer Kelly, Gibson DaCruz & David Wright, “A Qualitative Study of the Problems Surrounding Medicine Administration to Patients with Dysphasia” (2009) 24 Dysphagia 49 at 53: “Managing medicines for patients with dysphagia can lead to ethical dilemmas such as covert administration: “When crushed tablets are mixed with the patient’s food, particularly when the patient has competency problems, and you are not sure of that patient’s knowledge of actually taking the medication.””
533 Sealy & Whitehead (2004), supra note 9. See also Honourable Chief Justice McLachlin (2010), supra note 87 at 20: “While a necessary step, the rapid de-institutionalization of mental health care of the 1970s and 1980s created new problems. Many newly released patients were ill-prepared for transition into society. Frequently, the medications had unpleasant side-effects. Lacking close supervision, patients all too often stopped taking these medications. The result? People with mental illness on the street, seemingly without care or hope. We are still struggling with the problems flowing from deinstitutionalization.”
534 Kaiser (2001), supra note 10 at 391: “Acute care hospitals remain a significant component of the Canadian mental health services mosaic.”
535 Kilty (2008), supra note 163 at 4: “[During deinstitutionalization,] psy gained significant control within the criminal justice system.”
homeless without any access to health services.”536 Many “fall through the cracks”, after being discharged from hospital to the street, and end up in the justice system.537 This revolving door between jail, hospital and the community means that more people end up in emergency rooms. Community-based mental health supports prevent hospitalization and reduce the need for the covert administration of medication.

Nurse- and psychiatrist-participants did not directly address the burdens on staff in busy inpatient units or whether those burdens drive covert medication. However, workplace pressures underlay their comments. Wards are busy and hectic and may be understaffed. In a high-pressure, stressful workplace, health care providers may feel compelled to rely on tools, like the covert administration of medication, to ensure medication compliance.538 In the long-term care setting, Kirkevold and Engedal (2005) reported that high staffing ratios were associated with the lower covert medication rates.539 Duxbury and others (2010) surveyed nurses about their experience of medication administration and reported that time constraints and heavy workplace demands impacted nurses' medication practices.540 HCPs may not have time to work with patients to fully understand the reasons they do not want to take their medications. HCPs may be under pressure to make quick decisions about how to administer medication, without time to prepare paperwork or consult with the rest of the team (including the pharmacist).

While not raised by the participants, the delivery of pro re nata (PRN) medication raises

536 Gable & Gostin (2009) supra note 11 at 252.
537 Frankel (2003), supra note 12 at 7: “For many of those who have left institutions in the last forty years, however, deinstitutionalization has delivered much less than it promised. More often than not, the transition to community living has proved to be difficult, even disastrous. Instead of the welcoming arms of the community, many leaving mental institutions have found themselves increasingly shunned, isolated, and marginalized.”
539 Kirkevold & Engedal (2005), supra note 357.
540 Joy A Duxbury, Karen Wright, Diane Bradley & Pamela Barnes, “Administration of Medication in the Acute Mental Health Ward: Perspective of Nurses and Patients” (2010) 19:1 Int J Mental Health Nurs 53 at 58: “They frequently made reference to the ‘stressful’ nature of the task and the need to maintain their concentration in the midst of competing demands. The literature is dominated by discussions about medication errors, and this is further compounded by the distractions that occur simultaneously and that contribute to the stressful and chaotic nature of the wards.”
additional and related questions. Like covert medication, PRN medication practices are characterized by a “lack of clarity surrounding psychotropic PRN medication administration practices, confusion surrounding decision-making processes related to this intervention, and poor documentation practices.”

Dosages are administered as needed or as the situation arises and determined mainly by nursing staff. Despite its alternatives, PRN medication is frequently prescribed and administered in mental health facilities. The UK’s Care Commission and Mental Welfare Care Commission reported that the administration of PRN medication was not documented consistently.

The decision to deliver PRN medication may be subject to bias, including racial biases or may depend on a particular diagnoses. There is little evidence about its practice, and it is likely based on professional experience and habit. There is some evidence that PRN medication rates are higher at night, when staffing levels are lower. The covert administration of medication and PRN practices may be analogous responses to barriers to administrating medication in psychiatric settings.

Concerns regarding medication administration have also been raised in long-term care (LTC) settings. Staff shortages may contribute to over-reliance on medication in LTC, despite concerns about the risks associated with the administration of those medications.

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542 Usher, Lindsay & Sellen (2001), supra note 542.
545 Care Commission and Mental Welfare Commission (2009), supra note 351 at 50.
547 Szczesny & Miller (2003), supra note 544.
550 Curtis & Capp (2003), supra note 548.
to older adults.\textsuperscript{551} The Canadian Institute for Health Information (2012) reported that about two-thirds of older-age residents are taking at least ten drugs to treat a wide range of conditions (sometimes off-label).\textsuperscript{552} Hughes (2008) challenged the inappropriate and over medicating of older adults in UK nursing care, including the use of chemical restraints used to “sedate a patient as a means of convenience.”\textsuperscript{553} Using focus group interviews with nursing home staff, Gjerberg and others (2013) considered the use of coercion in nursing homes in Norway. Participants reflected on the barriers associated with strategies designed to avoid coercion. Staff shortages may lead to the unnecessary use of medication as suggested by one interviewee:

\textit{“...they don’t choose it themselves, they don’t ask for medicine... We have observed it several times; we can sit and talk to them, walk with them, or sit down and hold their hands, and then they don’t need the extra medicine. But when we don’t have the money or the resources, then it is ok to... we can afford some extra medicine.”} \textsuperscript{554}

There is emergent data about the overuse of medication in federal prisons, sometimes

\begin{itemize}
\item John O’Brien, “Antipsychotics for People with Dementia” (2008) 337:7661 BMJ 64 at 65: “Antipsychotics, especially atypical ones, have the best evidence base, although their efficacy is more modest than previously supposed and their side effects more serious. Prescribing rates of up to 50% for people in residential care cannot be justified.”;
\item John Muench & Ann M Hamer, “Adverse Effects of Antipsychotic Medications” (201) 81:5 Am Fam Physician 617 at 622: “Antipsychotic medications have been used in older patients who have dementia-related psychosis or behavioral difficulties. In April 2005, the FDA issued a boxed warning for SGAs [second generation antipsychotics] after a meta-analysis showed a 1.6- to 1.7-fold increase in the risk of death associated with their use in this population. In June 2008, after two large cohort studies showed similar risk with FGAs [first generation antipsychotics], boxed warnings were added to this class as well. The cause of this increased mortality is at least in part from sudden cardiac death, as well as cerebrovascular accidents. Currently, there are no medications approved for the treatment of dementia-related psychosis. Before medication is prescribed, behavioral interventions should be attempted. Any use of antipsychotics for dementia-related psychosis should be preceded by a discussion with patients, families, and caregivers about the increased risk of cerebrovascular accidents and death.”
\item Canadian Institute for Health Information, Drug Use Among Seniors on Public Drug Programs in Canada, 2012 (Toronto: CIHI, 2014). At page 31, CIHI reports that older LTC residents take more medications than older adults living in the community. In 2012, the rate of use of benzodiazepines (including zopiclone, which is considered a benzodiazepine-related drug), antidepressants and antipsychotics among seniors in LTC facilities was roughly two, three and nine times higher, respectively, than among seniors living in the community.
\item Rhidian Hughes, “Chemical Restraint in Nursing Older People” (2008) 20:3 Nursing Older People 33.
\end{itemize}
described as “the de facto mental health system.”\textsuperscript{555} As in long-term care, it may be that correctional staff have few options to support prisoners with mental health issues, given shrinking resources, overcrowding and staff shortages. A recent report found that 60% of female inmates in Canada are prescribed psychotropic medications, sometimes off-label.\textsuperscript{556} Advocates claim that the antipsychotic, quetiapine, is used to manage, sedate, control and subdue difficult inmates, despite the medication's serious side effects.\textsuperscript{557}

Drawing on recent law and society scholarship, outlined in Chapter 2 (“Theoretical Framework”), Kilty (2012) characterized the overuse of prescription psychotropic medications as a governance strategy.\textsuperscript{558} In an earlier article, Kilty (2008) contended that medications are used to “sedate rowdy or misbehaving prisoners.”\textsuperscript{559}

\textbf{iii) The Unavailability of Professional Guidance and Institutional Silences}

Partly because the practice of covert medication is covert, the practice remains under-litigated, under-theorized and under-researched. Most interview and focus group participants were unaware of the availability of institutional policies or professional guidance that governed the covert administration of medication. The document analysis revealed that there is little guidance offered to HCPs about covert medication. Nevertheless, this practice raises significant questions surrounding the professional duties and obligations of HCPs. There are additional questions about the responsibility of institutions to develop and implement policies about the covert administration of medication, as is the case in the UK.\textsuperscript{560}

These institutional “silences” contribute to the discomfort surrounding the practice. One

\textsuperscript{555} Gable & Gostin (2009) \textit{supra} note 11 at 253.
\textsuperscript{556} “Powerful antipsychotic drug Seroquel used in Canada’s federal prisons”, \textit{Toronto Star} (14 April 2014).
\textsuperscript{557} Timothy Sawa, “Prisoners given powerful drugs off-label, allegedly to 'control behaviour', \textit{CBC} (14 April 2014).
\textsuperscript{558} Jennifer M Kilty, “It's Like They Don't Want You to Get Better': Practicing Psy in the Carceral Context” (2012) 22:2 Feminism & Psychology 162.
\textsuperscript{559} Kilty (2008), \textit{supra} note 163: “Psy no longer stresses the importance of therapy in conjunction with psychopharmaceutical treatment; instead, it exists within the correctional system based almost solely on its ability to prescribe medications to prisoner populations.”
\textsuperscript{560} Royal College UK, \textit{supra} note 330: “16. Trusts and organizations should develop a policy on this issue.”
nursing-participant expressed concern that she would "get in trouble" for speaking about the practice. This confusion and silence contribute to HCP’s “moral distress”\(^{561}\), compassion fatigue or burnout. In Australia, Barnes and others (2006) interviewed nurses about the practice of altering medication dose forms. While nurses felt constrained to ensure that prescribed medication was administered to residents, they expressed anxiety about working in an “information vacuum.”\(^{562}\)

Most scholars agree that the lack of transparency about the practice impairs a full conversation about the practice. A culture of fear drives the practice underground.\(^{563}\) Treloar, Philpot and Beats (2001) argued that the most worrisome aspect of the practice of the covert medication was the “lack of openness and poor recording that surrounds the issue.”\(^{564}\) Considering coerced medication generally, Jarret, Bowers and Simpson (2008) worried that “[t]he dearth of literature on this topic means that coerced medication is not an evidenced-based practice.”\(^{565}\) Fears of professional censure likely inhibit public debate about the covert administration of medication.\(^{566}\)

Institutions may fear scrutiny or liability, impairing open and transparent debates about the practice. Chapter 6 (“Results”) includes additional detail about the researcher’s experience seeking access to clinical policies at two facilities in Ontario. The

\(^{561}\) Bernadine Wojtowicz, Brad Hagen-Van & Cheryl Daalen-Smith, “No Place to Turn: Nursing Students’ Experiences of Moral Distress in Mental Health Settings” (2013) 23:3 Int J Mental Health Nurs 257 at 4: “…three participants stated that a significant source of moral distress for them were instances where they felt that important information (often about medications) was being withheld from patients, and in some cases, they were even being ‘tricked.’”

\(^{562}\) Barnes \textit{et al} (2006), \textit{supra} note 354.

\(^{563}\) Treloar, Beasts & Philpot (2000), \textit{supra} note 364 at 410: “We were, however, concerned about the secrecy and lack of controls, and about the absence of discussion with pharmacists regarding advisability. […] This disturbing picture may be attributable to a culture of fear surrounding covert medication, in which written guidelines are lacking and concern about litigation drives the practice underground.”

\(^{564}\) Treloar, Philpot & Beats (2001) \textit{supra} note 375 at 62.

\(^{565}\) Jarret, Bowers & Simpson (2008), \textit{supra} note 1 at 547.

\(^{566}\) Lewin \textit{et al} (2006), \textit{supra} note 18 at 77: “The practice of covertly medicating may not be uncommon in EDs, but fear of professional censure probably inhibits open discussion and documentation of such events.” See also Wong, Poon & Hui (2005), \textit{supra} note 18 at 262: “These risks are amplified when the practice remains unregulated and unmonitored because of a lack of legal or professional guidelines, and of the secrecy surrounding the practice due to fear of professional censure.”
administrative barriers to the disclosure of those policies and practice guidelines reinforce the "covertness" of the practice. Those barriers may also reflect discomfort surrounding the practice and signal an apparent reluctance to engage in overt discussion or debate about it. Without open discussion, the practice may remain unnamed and underreported; it may flourish without oversight or accountability.

iv) Dementia

Most of the research reviewed in Chapter 4 ("Literature Review") considered the practice with older adults. This research excludes consideration of the practice in long-term care settings, given its distinct administrative and legal contexts. This research focused, instead, on its practice in psychiatric settings, including in psychogeriatric inpatient units. Participants observed the differences between the practice for psychogeriatric patients and other psychiatric inpatients. One of the three scenarios included a person diagnosed with dementia-related psychosis. In discussions about that scenario, participants suggested that it was easier to justify the practice when a patient had dementia because the patient was unlikely to regain capacity. Dementia and incapacity were sometimes used interchangeably in the focus group and interview discussions.

Consideration of these issues raises questions about the intersection of ageism and ableism (See “Responding to Diversity”, below). It might be that age and disability discrimination operate together as a powerful predictor of social exclusion. It may also be that psycho-geriatric patients experience barriers to high quality substitute decision-making. Since social exclusion increases with age, older inpatients may have to rely on Ontario Public Guardian and Trustee or unengaged family members to act as SDMs. Not specific to geriatric psychiatric settings, scholarship has offered evidence of family members’ inability to predict elderly patients’ preferences regarding

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Follow-up research may consider the quality of substitute decision-making for different types of disabilities and its impact on covert medication.

II. CONSTRUCTING INCAPACITY

Covert medication may be described as an intervention to improve treatment adherence. Other interventions include CBT-based adherence therapy, long-acting injections and supervised community treatment. However, Aldridge (2012) questioned the underlying philosophy of interventions “[w]here an adherence improvement approach might see increased adherence as the essential objective, such approaches could disable genuine collaboration.” Instead, Aldridge proposed a “harm reduction” approach to reduce the harm of stopping antipsychotics “by informing and supporting those who make this personal decision.”

i) Recovery-Focused and Patient-Centeredness

Reminiscent of Aldridge’s emphasis on collaboration, participants described covert medication as precluding the patient from participating in treatment decision-making. As the entire health care team knows about the practice, rather than being part of the team, the patient becomes the subject of surveillance.

As an alternative to covert medication, some focus group and interview participants considered the value of recovery-focused and patient-centered approaches. Decision-making and goal setting should include patient choice. Rather than relying on strategies to improve compliance in the short-term, an approach that is client-centered is more likely to lead to recovery. Client-centered approaches to recovery offer persons an
active role in their own treatment. This comports with Ontario’s shift from traditional medical services that focus on symptom management to approaches that emphasize “collaborating in self-directed services focused on wellbeing.”

It is a common misconception that mental health issues are life-long. Too often, people are told that a psychiatric diagnosis means certain deterioration. A recovery-oriented system goes beyond symptom reduction and focuses on improving quality of life. Some participants characterized covert medication as “autonomy restoring” since it ultimately supports patients to make their own decisions after a few doses. On the other hand, some participants commented on the impact of the practice on a person’s long-term prospects for “real” recovery. If the patient does not know about the covert medication as they transfer from the inpatient unit, it may be difficult for them to remain well in the community. If the patient does not know about the medication, she would not

reduction, has become the primary focus of treatment, and there is an emerging emphasis on person-centered care.” See also Petrila & Swanson (2010), supra note 35 at 13: “… the late Victorian ideal of mental respite in the asylum’s pastoral setting had given way to a new therapeutic concept of recovery in the community that assumed that contact with family and friends and the trappings of a normal life was almost inherently salubrious, and indeed that this was needed as the antidote to the socially toxic influences of confinement in a massive mental hospital.”

 Izabel Marin, Roberto Mezzina, Marit Borg, Alain Topor, Martha Lawless, Dave Selles & Larry Davidson, “The Person’s Role in Recovery” (2005) 88 Am J Psychiatr Rehab 223. See, however, Eluned Dorkins, Glenn Roberts, James Wooldridge & Elaine Hewis, “Detained- What’s My Choice, Part 2: Conclusions and Recommendations” (2008) 14 Adv Psychiatr Treatment 172 at 186: “There are many contributing processes that help or hinder recovery for detained patients, and the judicious exercise of choice appears to be a key consideration. We think that the issue is about optimising rather than maximising choice in ways that reflect an individual’s capacity both to make good choices and to responsibly take constructive risks.”


 Barbara Everett, Barb Adams , Jean Johnson , George Kurzawa, Marion Quigley & Marion Wright, Recovery Rediscovered: Implications for the Ontario Mental Health System (Toronto: CMHA Ontario, 2003), online: CMHA < ontario.cmha.ca/download.php?docid=510 > at 2: “Nonetheless, a philosophy of recovery provides a beacon of hope where too often, people are told that mental illness means certain decline into unemployment, poverty, and disability.”

 Peter Barker & Poppy Buchanan-Barker, “Myth of Mental Health Nursing and the Challenge of Recovery” (2011) 20 Int J Ment Health Nurs 337 at 341: “ Much of the traditional discourse on psychiatric mental health nursing remains focused on the treatment or management of ‘patients.’”

 Government of Canada, The Human Face of Mental Health and Mental Illness in Canada 2006 (Ottawa: Minister of Public Works and Government Services, 2006) at 47. See also Honourable Michael Kirby, Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services In Canada (Ottawa: Standing Senate Committee on Social Affairs, Science and Technology, May 2006) at 42.
know why she got better in the hospital, interfering with her prospects for long-term recovery.

Other participants considered covert medication’s impact on patient focus and engagement. The practice excludes the patient’s perspective, including underlying reasons for refusing medication. The patient is unable to report upon the medication’s side effects or on its efficacy. According to the Mental Welfare Commission in Scotland, “[c]overt medication is no substitute for explanation and education.” To facilitate patient engagement, an HCP may debrief patients and advise them of the fact of the covert administration of medication. Without commenting specifically on covert medication, Lorem and others (2014) surveyed patients’ experience with medication following crisis. They recommended an “increased emphasis on providing information and participating in a dialogue about drug treatment options.” In particular, debriefing following coercion “can be a practical tool for clarifying patient preferences and mutual understanding.”

Shared decision-making is an alternative approach to making treatment decisions. It perceives both the HCP and the patients as experts. Deegan and Drake (2006) challenged the traditional compliance model’s emphasis on obedience to medical authority. They argued that “compliance is rooted in medical paternalism and is at odds with principles of person-centered care...” Shared decision-making supports recovery by involving patients in decisions about their care and treatment. Similarly, the UK’s NICE (2009) guidelines recommend “collaborative” decision-making in antipsychotic prescribing.

578 Mental Welfare Commission for Scotland (2013), supra note 333 at 4: “Incapacity can be temporary or permanent. A person with temporary incapacity could regain capacity to decide about treatment. Covert medication is no substitute for explanation and education. It should only be considered if impaired intellectual function makes this impossible.”
580 Lorem et al (2013), supra note 579 at 347: “The use of debriefing during hospitalisation and following coercion can be a practical tool for clarifying patient preferences and mutual understanding.”
582 National Institute for Health and Clinical Excellence, Schizophrenia: Core Interventions In The Treatment
ii) Disentangling Competence and Compliance, including Medicalization

Relying on critical accounts of disability, this research considered the construction of the authority of persons with mental health issues to consent to or reject treatment. While this research is limited to the practice where an adult inpatient has been determined to be incapable of making treatment decisions, there are important considerations about the strength of the capacity determination.

A narrow conceptualization of capacity underlies the practice of the covert administration of medication. Some focus group participants acknowledged that this approach leads to a black and white understanding: a clear line between capacity and incapacity. Indeed, capacity is issue specific. A person may be capable of consenting to some things but not others. In addition, capacity fluctuates over time. There may be times in a person’s life where a person is capable of making certain types of decisions and other times where this is not so. Capacity is not the same as intelligence and cannot be measured using cognitive tests. While these legal principles are “on the books”, there are question about their expression in real-world clinical situations.

Covert medication impairs patient access to information about their treatment, including opportunities to make “bad decisions” to resist prescribed medication. Davidson (2008)

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583 Joint Statement (1999), supra note 321 at 5: “Competence can be difficult to assess because it is not always a constant state. A person may be competent to make decisions regarding some aspects of life but not others; as well, competence can be intermittent: a person may be lucid and oriented at certain times of the day and not at others. The legal definition and assessment of competence are governed by the provinces or territories. Health care providers should be aware of existing laws relevant to the assessment and documentation of incompetence (e.g., capacity to consent and age-of-consent legislation).”


asserted that “[c]overt medication denies patients the opportunity to consent to or refuse treatment.” However, incapacity is not the same as making a “wrong” decision. A person who makes a decision that others perceive as foolish or ‘risky’ is not necessarily incapable. Indeed, “[t]he right to be foolish is an incident of living in a free and democratic society.”

The “‘either/or” approach produces and maintains incapacity. Refusing medication may be considered as evidence of lack of insight. That is, if a patient incompetently complies with medication, an HCP will not challenge her capacity, but if a patient resists her medication, her capacity may be impugned. A refusal to take medication may be justification for asserting the authority of an SDM to act in her best interests. Covert medication also conceives of capacity as producible by medication since (as described by psychiatrist-participants) patients may be able to make their own capable decisions after a few hidden doses.

This all-or-nothing approach to determining capacity is distinguished from an approach that imagines capacity as able to be fostered. Rather than finding a person to be either capable or incapable, a supported decision-making approach offers assistance to a person to make her own decision. Sherwin (1998) articulated a feminist reconceptualization of autonomy, which denies that autonomy requires self-sufficiency and is compatible with the supported decision making models. The LCO characterized

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586 Davidson, supra note 390.
587 Starson v Swayne, supra note 284 at para 112: “If Professor Starson is capable, he is fully entitled to make a decision that the Board, or other reasonable persons, may perceive as foolish. The Board improperly allowed its own conception of Professor Starson’s best interests to influence its finding of incapacity.”
588 Koch (Re), [1997] OJ No 1487, 33 OR (3d) 485 [QL] (Gen Div) at 512.
589 For additional detail on supported decision making models see Michael Bach & Lana Kerzner, “A New Paradigm for Protecting Autonomy and the Right to Legal Capacity” (Toronto: LCO, 2010), online: LCO <www.lco-cdo.org/disabilities-commissioned-paper-bach-kerzner.pdf>.
590 Sherwin (1998), supra note 156 at 38: “The best way of course to help oppressed people to develop autonomy skills is to remove the conditions of their oppression. Short of that, long-term social projects can help provide educational opportunities to counter to psychological burdens of oppression. In the short term, it may be necessary to spend more time that usual in supporting patients in the deliberative process of decision-making and providing them with access to relevant political as well as medical information...."
“relational autonomy” as recognizing that people make decisions in consultation with others. Chapter 4 (“Literature Review”) highlights the CRPD provisions about supported decision-making.

Some legal-participants challenged the emphasis that covert medication places on medication. The decision to covertly administer medication relies on faith that medication will be effective. It focuses on the importance of getting medication into a patient. One participant remarked on the “mythology” that “everything hinges on medication” and pointed out that “...most facilities don’t have real programming apart from medication management.” Calling for a more collaborative approach to prescription practices, Morrison and others (2012) pointed to recent evidence challenging the effectiveness of antipsychotic medication. Finding that an emphasis on medication adherence underestimates the value of alternatives to medication, Lorem and others (2014) asserted, “...reducing problems in living to merely a question of ‘mental disease’ that can only be ‘treated’ with psychiatric drugs is a simplification that overlooks the complexity of the situation.” The practice’s focus on treatment adherence suggests that HCP’s must do everything to get medications to patients.

i ii) Understanding Risk and Resistance

Covert medication invokes overlapping concepts of risk and resistance. Treatment non-adherence is conceptualized as dangerous or risky. A person who resists medication is conceived of as needing to be managed. Rose (2000) argued that, in modern liberal states, people are primarily governed through self-regulation, rather than by force. That self-regulation, also known as ‘responsibilization’, is impugned when someone refuses medication. Covert medication presumes that an inpatient has failed to be responsible by resisting or refusing medication.

591 LCO Framework (2012), supra note 63 at 78.
592 Morrison, Hutton, Shiers & Turkington (2012), supra note 530.
593 Lorem et al(2014), supra note 584 at 348.
594 Rose (2010), supra note 161 at 85.
Patients are constituted as risky if they do not comply with medical decision-making. A recent rise in risk-based thinking characterizes modern psychiatric system(s).\textsuperscript{595} Though not specifically about covert medication, Rose (2010) described this as “governance through neurochemistry.”

Risk assessment in the name of the prevention of relapse has become entwined with strategies for pre-emptive intervention in the name of community safety; with the dream – or nightmare – that it is possible to identify and exclude those who are incorrigibly risky and potentially monstrous – incarceration without reform.\textsuperscript{596}

Recent Law and Society scholarship considers the expansion of law’s reach beyond traditional justice systems. For instance, Beckett and Murakawa (2012) considered the “shadow carceral state”, which operates beyond criminal law and justice systems. They explored the “more submerged, serpentine forms of punishment that work in legally hybrid and institutionally variegated ways.”\textsuperscript{597} Covert medication operates under the radar and manages “risky” and “resistant” inpatients without having to resort to the law.

\textsuperscript{595} Rose (2010), supra note 161 at 88: “Psychiatry itself has been reoriented within these strategies of control formulated in terms of risk.”

\textsuperscript{596} Rose (2010), supra note 161 at 88. “To satisfy the public and political demand for the identification of the potentially monstrous, psychiatric risk-thinking has come to connect the routine management of those with a history of psychiatric troubles and the problem of the identification of the exception along a single dimension of risk assessment. … Historical precedents would suggest that such strategies are unlikely to reduce the overall frequency of the very rare incidents they seek to prevent. But they are likely to result in threshold-lowering and net-widening, and the detention of many individuals who are capable of leading lives that might sometimes be troublingly different but would pose no dangers to others”.

\textsuperscript{597} Beckett & Murakawa(2012), supra note 160 at 22: “Here, we map the more submerged, serpentine forms of punishment that work in legally hybrid and institutionally variegated ways. Our analysis shows how overt get-tough policies and rhetoric are supplemented and extended by a range of seemingly small policy innovations and complex institutional adaptations, including the creation of civil ‘alternatives’ to criminal sanctions, coercive efforts to recoup criminal justice expenditures, and heightened immigration enforcement. The sanctions that have been created and imposed through these adaptations are not necessarily imposed via criminal law or processed through criminal justice institutions. Nonetheless, they significantly enhance carceral state power.”
III. LAW’S IMPACT AT ITS BOUNDARIES

Participants in the focus groups and interviews understood that covert medication had something to do with rights. In the focus groups and individual interviews, the term "rights" was often raised. There was, however, confusion about how those rights applied. Participants appeared to be unsure about how those rights played out in the case of covert medication.

This research relied on a broad understanding of “patients’ rights experiences”, as set out by the second Research Question. It offered attention to the practice’s clinical impacts, which have a secondary impact on the patient’s rights-experience. For instance, the clinical impacts of the covert administration of medication indirectly impair the person’s ability to challenge the practice. The value of this definitional turn became clear during the data analysis. Participants’ commentary on “rights” seemed to be wrapped up with the concepts of recovery and wellbeing. To reflect that commentary, “rights” were defined very broadly to include “right to health” and “right to recovery”. Indeed, as set out in Chapter 2 (“Theoretical Frameworks”), rights and health are intertwined and interdependent and, as stated by the World Health Organization, “promoting and protecting health and respecting, protecting and fulfilling human rights are inextricably linked.”

Moving beyond traditional approaches to rights and autonomy, Gable and Gostin (2009) asserted that a minimum level of mental health is necessary to ensure the enjoyment of other human rights.

i) Unanswered Legal Questions

Specific unanswered legal questions about the covert administration of medication were identified during the focus groups, individual interviews and the literature review. Most problematically, there are barriers to bring these questions before a tribunal or Court. If

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599 Gable & Gostin (2009), supra note 11 at 250.
neither the patient nor the SDM is aware of the covert administration of medication, they are unable to challenge it. Flowing from Chapter 6 (“Results”), specific and unanswered legal questions include:

- Must the SDM provide specific consent to the hiding of the medication? While the SDM must consent to the medication, it is not clear whether the SDM must consent to the form or the route of administration.
- Does the practice of covert medication expose institutions or HCPs to claims of malpractice, fraud, assault, battery or breach of the duty to obtain informed consent?
- Do protections against abuse/neglect require the HCP to do everything possible to deliver medication (properly consented to by an SDM) to an adult inpatient? On the other hand, could it amount to abuse to treat illness without the incapable person's knowledge? Does the answer depend on whether the SDM explicitly consented to the concealment of medication?
- Should the covert administration of medication be an intervention of last resort, in that all possible alternative interventions (including psychoeducation and health-teaching) are exhausted before deciding to covertly administer medication?
- Could the covert administration of medication amount to the application of a chemical restraint in a particular clinical context? Could the rules about the chemical restraints apply to the covert administration of medication?
- If an inpatient regains capacity to consent to treatment, should she be advised of the fact of the covert administration of medication?
- If the covert administration of medication is justifiable under law, what are the particular requirements for its practice, including documentation?
- Should psychiatric facilities be required to have a clinical policy, protocol or procedure about the covert administration of medication?
- If an HCP is asked directly whether medication has been hidden in food, does she have a duty to tell the truth?
ii) Review of Relevant Legal Principles

This section builds on the review of domestic and international law described in Chapter 4 ("Literature Review") as well as on the results of the document review, reported in Chapter 5 ("Results"). It synthesizes relevant legal principles that apply to the covert administration of medication, relying on the LCO Framework set out in Chapter 2 ("Theoretical Frameworks"). These legal principles compete: the various legal principles both support and reject the practice of covert medication. It is worth emphasizing that these arguments remain untested, given the barriers to bringing these questions before a Court or tribunal. The Mental Health Commission of Canada developed the *Mental Health and Human Rights Evaluation Instrument* for the purpose of “evaluating the extent to which current provincial and territorial mental health legislation, policies and standards reflect the key principles and human rights of persons living with a mental illness.”

The MHCC’s instrument highlights principles and rights that complement the LCO's Framework.

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601 MHCC Evaluation Instrument (2011), *supra* note 600. The MHCC Evaluation Instrument highlights the nine human rights principles to support an evaluation the extent to which legislation, policies and standards comport with the human rights of persons with mental health issues: Principle 1: Respect for the inherent dignity, individual autonomy and independence including the freedom to make one's own choices; Principle 2: Non-discrimination and equality of opportunity; Principle 3: Full and effective participation and inclusion in society; Principle 4: Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity; Principle 5: Accessibility; Principle 6: Equality between men and women; Principle 7: Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities; Principle 8: Respect for cultural diversity, including language, values, beliefs and traditions; Principle 9: Transparency and accountability. The MHCC Evaluation also enumerates eighteen human rights to guide an evaluation of legislation, policies and standards: Right 1: Right to life; Right 3: Equal recognition before the law; Right 4: Access to justice; Right 5: Liberty and security of the person; Right 6: Freedom from torture or cruel, inhuman or degrading treatment or punishment; Right 7: Freedom from exploitation, violence and abuse; and Right 13: Health.
1. Respecting Dignity and Worth of Persons with Disabilities

The covert administration of medication raises questions about protections from discrimination on the grounds of disability and age. The LCO described this first principle as “recogniz[ing] the inherent, equal and inalienable worth of every individual, including every person with a disability” and a “direct challenge to stereotypes and negative attitudes towards persons with disabilities.” Section 15 of the Charter of Rights and Freedoms and Ontario’s Human Rights Code complements this principle. Article 2 of the International Covenant on Economic, Social, and Cultural Rights and Article 5 of the CRPD set out protections against discrimination on the ground of disability. Article 25 of the CRPD protects against the “discriminatory denial of health care or health services or food and fluids on the basis of disability.” Despite the fact the ICESCR does not refer explicitly to persons with disabilities, the Committee on Social and Economic Rights declared that persons with disabilities must be “provided with the same level of medical care within the same system as other members of society.”

In R v Swain [1991], the Supreme Court of Canada recognized that persons with mental disabilities have experienced considerable historical disadvantage and stereotypes. According to Chief Justice Lamer, “The mentally ill have historically been the subjects of abuse, neglect and discrimination in our society. The stigma of mental illness can be very

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602 LCO Framework (2012), supra note 63 at 66.
603 LCO Framework (2012), supra note 63 at 66: “All members of the human family are full persons, with the right to be valued, respected and considered and to have both one’s contributions and needs recognized.”
604 Charter, supra note 105 at s 15. See Section III.v (“Nature and Value of Rights”) below, about the Charter’s application to health claims.
606 ICESCR, supra note 247 at Article 2.
607 CRPD, supra note 108 at Article 5 (“Equality and Non-discrimination).
608 CRPD, supra note 108 at Article 25 (“Health”).
609 General Comment 5, supra note 252 at para 34: “The right to physical and mental health also implies the right to have access to, and to benefit from, those medical and social services - including orthopaedic devices - which enable persons with disabilities to become independent, prevent further disabilities and support their social integration.”
damaging.” Kaiser (2001) considered the experience of discrimination by persons in psychiatric settings who are subject to restraints and seclusion:

Already victims of the stigmatization, marginalization and impoverishment that often accompany mental illness and intellectual disability, some persons in institutions are subject to the further indignity of extreme physical isolation, restrictive of movement and chemical restraints.

In her lecture “Medicine and the Law: The Challenges of Mental Illness”, Chief Justice McLachlin remarked on the pervasive stigmatization of persons with mental health issues, including our “failure to provide the care and treatment and consideration they deserve as human beings.”

It may be that covert medication is more commonly applied to persons with mental health issues than to persons with other capacity issues. It may be that medication for physical illness (e.g., insulin, heart medication) is less likely to be covertly administered to an incapable patient. Further research may explore whether patients with mental health issues are more likely to be subjected to covert medication than patients with other capacity issues.

2. Responding to Diversity in Human Abilities and Other Characteristics

The LCO’s second principle “requires recognition of and responsiveness to the dimensions of diversity.” Reminiscent of critical disability studies, as set out in

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610 R v Swain, supra note 74 at para 994. See also Nova Scotia (Workers’ Compensation Board) v Laseur, supra note 74 at para 90: “This Court has consistently recognized that persons with mental disabilities have suffered considerable historical disadvantage and stereotypes.”

611 Kaiser (2001), supra note 10 at 391.

612 Honourable Chief Justice McLachlin (2010), supra note 87 at 17. “The sad truth is that we still too often stigmatize people with mental illness. We still too often fail to provide the care and treatment and consideration they deserve as human beings. In this way, we commit the modern equivalent of the past sins of incarceration. Notwithstanding modern knowledge and modern treatments, we still have a long way to go in meeting the mental health challenge.”

613 This argument was unsuccessful before Ontario’s Superior Court in SMT (2008), supra note 290.

Chapter 2 “(Theoretical Frameworks”), disability may be understood as part of “universal human variation rather than an aberration.”\textsuperscript{615} Disability is, instead, part of the range of human experience.\textsuperscript{616} This principle aims to “move beyond stereotypes and to combat ableism and paternalism.”\textsuperscript{617}

Stereotypes about persons with mental health issues as “wholly incapable”\textsuperscript{618} may drive the decision to covertly administer medication. Gable and Gostin (2009) described “the myth of incompetency.”\textsuperscript{619} However, capacity is issue-specific, and a person may be capable of consenting to some things but not others. Staff may presume that a patient does not have the capacity to consent to other interventions, such as health teaching, to improve treatment adherence. Additionally, injurious stereotypes about persons with mental health issues as “dangerous” or “aggressive” may also drive the decision to covertly administer medication.

Stigma and stereotypes may not be applied equally to all classes of persons with mental health issues. While the three scenarios [Appendix C] included diverse inpatients, most participants did not comment on the influence of the patients’ socio-cultural locations on the decision to covertly medicate. It may be that these factors are deeply embedded. Other methodologies may be used to explore those questions.

\textsuperscript{615} Michael A Stein, ”Disability Human Rights” (2007) 95 Calif L Rev 75 at 121: ”Adopting a disability human rights model-and then extending it to other groups-repositions disability as a universal and inclusive concept. As human beings, each of us has strengths, weaknesses, abilities, and limitations. A disability human rights framework prioritizes potential over function, and recognizes the value of every individual for his or her own end. [...] Doing so embraces disability as a universal human variation, rather than as an aberration.”

\textsuperscript{616} LCO Framework (2012), supra note 63 at 71: “People exist along a continuum of abilities in many areas, that abilities will vary along the life course, and that each person with a disability is unique in needs, circumstances and identities; and the multiple and intersecting identities of persons with disabilities that may act to increase or diminish discrimination and disadvantage.”

\textsuperscript{617} LCO Framework (2012), supra note 63 at 73.

\textsuperscript{618} C Tess Sheldon & Ivana Petricone, Addressing the Capacity of Parties before Ontario’s Administrative Tribunals (Toronto: ARCH Disability Law Centre, 2009), online: ARCH <http://www.archdisabilitylaw.ca/addressing-capacity-parties-ontario’s-administrative-tribunals-respecting-autonomy-protecting-fairne> at 34: ”The presumption of incapacity of all persons with mental health issues incorporates a paternalistic approach that views people with disabilities as in need of care and charity.”

\textsuperscript{619} Gable & Gostin (2009) supra note 11 at 251: ”While some mentally disabled people lack competency, others have full competency or merely limited incapacity.”
Covert medication may be particularly prevalent in geriatric psychiatry units. CAMH’s covert medication policy appears to have originated in the geriatric unit. It may be that the experiences of discrimination on the ground of disability (mental health) and on the ground of age intersect. Indeed, the LCO pointed out that “old age is often conflated with impairment and disability, but the relationship is not so simple.” The under-examined relationship between disability and age may lead to presumptions about the capacity of older adults with dementia and/or mental health issues. The chapter highlights, below, areas of future research, including the influence of ableist or ageist biases. It may be that geriatric psychiatry inpatients are more likely to be presumed to be “wholly incapable” and subject to covert medication, without attention to alternatives, like health teaching.

3. Fostering Autonomy and Independence

The covert administration of medication invokes protections of the right to make one’s own decisions, reflective of the autonomy principle in the LCO’s Framework. On one hand, covert medication’s use of deception interferes with a person’s ability to make treatment decisions. On the other hand, medication administered covertly may serve to restore autonomy, allowing persons to make their own decisions later on.

In the case of covert medication, the practice’s use of deception makes it impossible for a person to make her own decisions. The CRPD’s guiding principle is respect for inherent dignity and individual autonomy, including the freedom to make one’s own choices. These protections are also reflected in the HCCA, which assures the primacy of prior

\[\text{\footnotesize 620 CAMH - FOI, supra note 495 at 1058. “The Geriatric Program originated this policy back in 2002. We use “covert mediation” practices almost daily with select inpatient clients, seldom more than 1 or 2 clients at a time.”} \]
\[\text{\footnotesize 621 LCO Framework (2012), supra note 63 at 14.} \]
\[\text{\footnotesize 622 LCO Framework (2012), supra note 63. See Section 7.II.ii,3: “Fostering Independence and Autonomy” below.} \]
\[\text{\footnotesize 623 CRPD, supra note 108 at Article 3 (“General Principles”).} \]
capable wishes. The HCCA also requires that the determination of best interests must include consideration of any wishes expressed by an incapable person about the treatment. As raised by the legal-participants, an incapable person may express her incapable wishes by resisting medication.

On the other hand, the administration (even covertly) of anti-psychotics may serve to restore autonomy. As raised by nurse- and psychiatrist-participants, medication administered covertly may permit persons to make their own treatment decisions later on. Reflecting on the meaning of “liberty”, Solomon and others (2009) reviewed the impact of the Supreme Court’s Starson decision, by reviewing case histories of persons where a court has overturned a finding of incapacity. They proposed legislative reforms to prevent people from “languishing untreated in hospital with little prospect for becoming well enough to regain their liberty.” A person’s incapable choice may be conceptualized as not truly “her own and genuine decision.” Hall (2012) elaborated on this concept:

In this way, the lack of mental capacity creates one of a limited number of exceptions to the general legal rule of non-interference with personal choices, however foolish, as a structural guarantor of personal liberty or autonomy. (Indeed, non-recognition protects the autonomy of the individual by refusing to enforce or recognize decisions that are not, truly, his or her own.)

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624 HCCA, supra note 194 at s 21(1).
625 HCCA, supra note 194 at s 21(2)(b).
626 Robert Solomon, John Gray, Richard O’Reilly & Martina Nikolic, “Treatment Delayed - Liberty Denied” (2009) 87:3 Can Bar Rev 679 at 681 [emphasis added]. See also at 718, where the authors consider the law’s real-world impact: “In attempting to protect autonomy, the Ontario law has imperiled the physical and mental health of involuntary psychiatric patients and exposed them to indeterminant detention. In our view, a better balance needs to be struck among the competing interests of these patients. In striking this balance, consideration must be given to the impact that the law has on lives of those it seeks to protect.”
628 Hall (2012), supra note 627 at 11 [emphasis original].
Autonomy requires the “creation of conditions to ensure that persons with disabilities are able to make choices ... with appropriate and adequate supports as required.”\(^{629}\) The LCO considered the interpretation of this principle to the case of Community Treatment Orders:

These [CTO] requirements are intended to facilitate living in safety and the ultimate goal of social inclusion and participation, but they mean that although strictly speaking the CTO regime is voluntary, it may be considered to contain a significant degree of coercion. In this way, CTOs may both support and undermine the principle of autonomy and independence, depending on one’s understandings of the principle—illustrating some of the difficulties in applying the principles. There is therefore a tension between principles in this policy, one which runs through much of mental health law, and is a subject of ongoing debate and discussion.\(^{630}\)

Additional research may consider the use of advance directives as a means to further secure the autonomy of persons who would otherwise be covertly medicated.

4. Promoting Social Inclusion and Participation

Because of its use of deception, covert medication makes it impossible for patients to participate in treatment decisions. The LCO described this principle as “promot[ing] the ability of all persons with disabilities to be actively involved with their community by removing physical, social, attitudinal and systemic barriers...”\(^{631}\) The LCO used the example of Ontario’s capacity laws to illustrate the application of the principle: “Persons with intellectual, cognitive or mental health disabilities may be restricted from participation in decisions affecting their daily living if found to lack legal capacity.”\(^{632}\)

An adult inpatient may require support to participate in treatment decisions. If she can

\(^{629}\) LCO Framework (2012), supra note 63 at 77. See also at 78. “Autonomy, or self-determination, means that the person is placed at the center of all decisions affecting him or her and may choose forms of supported decision-making.”

\(^{630}\) LCO Framework (2012), supra note 63 at 112 [emphasis added].

\(^{631}\) LCO Framework (2012), supra note 63 at 82.

\(^{632}\) LCO Framework (2012), supra note 63 at 84.
make her own decision with support, the covert administration of medication becomes unnecessary. As set out in Chapter 2 (“Theoretical Frameworks”), the LCO also characterized “relational autonomy” as emphasizing the value of “support and guidance necessary for the development and experience of autonomy.” Article 12 of the CRPD has been interpreted to require the replacement of substituted decision-making regimes with supported decision-making structures. Where a person has an intermediate level of capacity, she may be determined to be capable of making treatment decisions with support from a friend or family member.

The supported decision-making approach aims to enhance self-determination. People are assisted to participate in decisions where they might not otherwise have the legal capacity to make their own independent decisions. Five Canadian jurisdictions (British Columbia Yukon, Alberta, Saskatchewan and Manitoba) have passed legislation that references supported decision-making. In the case of covert medication, the UK’s Royal College provided:

> The patient should be unable to learn, even with support, and there should be a need for them to take medicine as well as a profoundly limited understanding of what is occurring. This will most often be due to severe dementia or profound learning disability.

If an adult inpatient can make her own capable decision with support, the need for

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633 LCO Framework (2012), supra note 63 at 78: “It is helpful to remember that autonomy is realized in the context of our relationships. This is not only true for persons with disabilities, but for all of us. Jennifer Nedelsky argues that it is relatedness, which enables people to gain autonomy; the relationships between ‘parents, teachers, friends, loved ones’ are what ‘provide the support and guidance necessary for the development and experience of autonomy.’”

634 CRPD, supra note 108 at Article 12: “3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.”

635 MHCC Evaluation Instrument (2011), supra note 600 at 10: “Supported decision-making refers to a process that assists persons living with a mental illness to exercise their legal capacity to make personal or property decisions. Supported decision-making is different from substitute decision-making because the person is making his or her own decision with support rather than having someone else making the decision for them. Supported decision-making may take different forms, for example the support person could explain the issues and choices available and, if necessary interpret the person’s preferences.”

636 James & Watts, supra note 268.

637 James & Watts (2014), supra note 636 at 5.

638 Royal College UK (2004), supra note 330 [emphasis added].
covert medication is obviated (since it is only permissible where the person has been
determined to be incapable).

5. Facilitating the Right to Live in Safety

This principle emphasizes the right of persons with disabilities to “live without fear of
abuse or exploitation and where appropriate to receive support in making decisions that
could have an impact on safety.”\(^{639}\) This principle interrelates with the others. For
instance, the principles of “Respecting Dignity” and “Fostering Autonomy” are
impossible to achieve without respect for the principle of safety. Indeed, the LCO pointed
out that “[t]he principle of safety has sources in the respect for the inherent worth and
dignity of persons with disabilities.”\(^{640}\)

Understandings of the right to health may influence the decision to covertly medicate
although its application can support or reject the practice. The failure to covertly
medicate may implicate the right to health.\(^{641}\) Proponents may justify the practice of the
covert administration of medication as a way to improve the care of persons determined

\(^{639}\) LCO Framework (2012), supra note 63 at 3.
\(^{640}\) LCO Framework (2012), supra note 63 at 94. See also at 86: “This principle has its roots in the
provisions of the CRPD that affirm the rights to liberty and security of the person; to freedom from torture
or cruel, inhuman or degrading treatment; to freedom from exploitation, violence and abuse; as well as
protections related to adequate standards of living and social protection and the attainment of the highest
achievable standard of health.”

\(^{641}\) Honourable Chief Justice Beverley McLachlin, “Medicine and the Law: The Challenge of Mental Illness”
(Honourable Mr. Justice Michael O’Byrne/AHRMR Lecture on Law, Medicine and Ethics, delivered at the
University of Alberta and University of Calgary, 17 & 18 February 2005) cited in Verdun-Jones & Lawrence
(2013), supra note 192 at 516ff: “On the other hand stands the argument that not treating severely
mentally ill persons on account of their refusal to consent represents a particularly impoverished
understanding of their rights and civil liberties. It assumes that the “formal” autonomy rights of persons
whose will and understanding are seriously impaired by illness should be preferred to their substantive
freedom and to other fundamental refusal to consent represents a particularly illness denies them. Failure
to treat may well result in permanent impairment of their right to be free from physical detention and
their right to have a mind free from debilitating delusions, terrifying hallucinations and irrational
thoughts. Although respecting a mentally ill person’s decision to refuse treatment formally accords them
equally treatment with non-mentally ill patients, abandoning such people to the torments of their illness,
mental and physical deterioration, substance abuse and perhaps suicide surely does not respect their
inherent dignity as human beings the argument concludes.”
to be incapable of making treatment decisions. It could be argued that persons have a right to those medications that are covertly administered if the SDM offers valid consent.

As raised by nurse- and psychiatrist-participants, medication administered covertly may improve health and wellbeing. As a therapeutic agent, the medication administered covertly may permit persons to make independent decisions later on. Article 25 of the CRPD articulates the right of persons with disabilities “to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.”642 In particular, the WHO commented on the lack of access to health and medical services for persons with mental health issues.643 The Standard Rules also comment on the right to health.644 The Royal College commented on the application of Article 2 of UK’s Human Rights Act (“Everyone’s right to life shall be protected by law”) to the covert administration of medication. The Royal College is clear that only medication for a therapeutic purpose may be covertly administered, impliedly excluding medication used solely to manage behaviour:

Where covert medication enables the provision of effective treatment to someone who would otherwise reject it, this article is used to justify such a practice. Clearly no treatment may be given covertly that is not specifically indicated for the treatment of illness or alleviation of distress (although such treatments may, sometimes, shorten life as a secondary result of their administration).645

Conversely, the covert administration of medication may impair a person’s right to health, particularly where medication is delivered without express consent to its concealment. If neither the patient nor SDM consents explicitly to the concealment, no one has been given the opportunity to refuse the concealment. Informed consent is

642 CRPD, supra note 108 at Article 25 (“Health”).
644 Standard Rules, supra note 257 at Rule 2: “States should ensure the provision of effective medical care to persons with disabilities.”
645 Royal College UK (2004), supra note 330 at 385: “Administration of treatments whose purpose is to shorten life is illegal.”
necessary to the enjoyment of the right to health and, as observed by the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, "that informed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision." General Comment 14 to the International Covenant on Economic, Social and Cultural Rights, includes that "a State’s obligation to refrain from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness...." The MHCC described the right to health as including the right to be “involved in the development of a treatment plan” and a right to services that “reflect the principles of recovery, self-empowerment, least restrictive, least intrusive and most effective.” The covert administration of medication raises questions about who is consenting to the medication's concealment.

The covert administration of medication may be justified or justifiable as a way to protect against abuse or neglect. In Ontario, the LTCHA and its 2010 Regulation codifies these protections in long-term care settings. Article 16 of the CRPD requires State Parties to guarantee freedom from exploitation, violence and abuse. It may be that these protections against abuse and neglect require the HCP to do everything possible to deliver medication (properly consented to by an SDM). On the other hand, it may amount to abuse to treat without the incapable person’s knowledge. The balancing of these two interpretations of the protections from abuse and neglect may depend on whether the SDM explicitly consented to the concealment of medication. The LCO’s Framework may be a useful tool to reconcile these interpretations.

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647 General Comment 14, supra note 134 at para 34.


649 LTCHA, supra note 27. See also LTCHA Regulation, supra note 30.

650 CRPD, supra note 108 at Article 16.

651 See e.g. Scott & Williams (1997), supra note 389 at 300: “With this in mind it is well to take account of arguments against deception: that it may potentially destroy trusting relationships with patients and, particularly, may represent the thin end of the wedge and give rise to abuse.”
Also related to the LCO’s “Right to Live in Safety” principle, the common law duty of restraint requires an HCP to restrain or confine a person when immediate action is necessary in order to prevent serious bodily harm to the person or to others. The HCCA reiterates the application of the common law duty. Hospitals owe a duty of care to its patients and may be liable for injuries between patients. An institution may have a positive obligation to restrain an individual in order to protect her safety as well as that of others. A hospital may be liable in tort where it breaches its duty to supervise and keep under reasonable control patients with “propensities to violent behaviour.” Case law from the UK also emphasizes that hospitals may be required to take positive steps to protect patients. The common law duty to restrain may be confined to those situations where restraint is used to prevent immediate bodily harm. The duty cannot be invoked to compel or force routine medications.

Some participants reflected, in general terms, about their duty to provide safe environments for other patients or staff. Balancing the rights of one patient against others (patients or staff) is another example of the tensions raised by covert medication. Such tensions mirror the struggles inherent in public health. The restriction of the

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652 HCCA, supra note 194 at s 7.
653 Stewart v Extendicare Ltd, [1986] SJ 419, (1986) 4 WWR 559, (1986) 38 CCLT 67, (1986) 48 Sask R 86 (QL) (Sask QB). The Saskatchewan Court of Queen’s Bench considered the duty of care owed by a nursing home to residents. That case involved an action against a nursing home alleged to be liable for the injuries to one resident by another resident.
654 Conway v Fleming, [1999] OJ No 880, 43 OR (3d) 92 (QL) (Gen Div): “After consultation by the staff and in accordance with a prn (a standing order to medicate if necessary) the defendants administered medication to restrain the plaintiff. The plaintiff’s action was for battery as against the defendants who administered the medication along with the administrator of the hospital.”
655 Wellesley Hospital v Lawson, [1978] 1 SCR 893 (Lexum) at 899.
656 Savage v South Essex Partnership NHS Foundation Trust [2008] UKHL 74, [2008] WLR (D) 386 (UK High Court). The UK High Court ruled that a local health authority was responsible for the death of a patient who left the hospital and committed suicide. The daughter of the patient claimed against the hospital, arguing Article 2 of the European Convention on Human Rights (“Right to Life”). The Court found that health authorities have an obligation to protect the lives of patients in their hospitals. In order to fulfill that obligation, and depending on the circumstances, they may be required to fulfill a number of positive obligations.
657 Similar arguments about the application of physical restraints to deliver routine medications were raised in SMT v Abouelnasr (2008), supra note 290. Ontario’s Superior Court did not offer guidance about how the common law duty to restrain applies in non-urgent situations.
liberties of persons with communicable diseases to protect the health of the community is an example of a public health legal question. Similarly, covert medication raises public mental health legal questions about the authority of the State (and its actors) to restrain and restrict persons with mental health issues.

Critics may characterize the covert administration of medication as inhuman or degrading, invoking Section 12 of the Charter. Provisions against inhuman and degrading treatment are also set out in Article 7 of the International Convention on Civil and Political Rights. Article 15 of the CRPD guarantees “freedom from torture or cruel, inhuman or degrading treatment or punishment.” The Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (2013) addressed “abuses in health-care settings that may cross a threshold of mistreatment that is tantamount to torture or cruel, inhuman or degrading treatment or punishment.” In particular, the Special Rapporteur considered “the use of psychiatric medication without the consent of the patient.” Calling for an absolute ban on the use of restraint and seclusion, the Special Rapporteur pointed out that the “environment of patient powerlessness...can lead to other non-consensual treatment, such as forced medication and electroshock procedures.” In 2008, the Special Rapporteur held that forced and non-consensual administration of psychiatric drugs must be closely

658 Charter, supra note 105 at 12: “Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.”
659 ICCPR, supra note 246 at Article 7.
660 CRPD, supra note 108 at Article 15 (“Freedom from torture or cruel, inhuman or degrading treatment or punishment” and Article 16 (“Freedom from exploitation, violence and abuse”).
661 Special Rapporteur-Torture (2013) supra note 275
662 Special Rapporteur-Torture (2013) supra note 275 at para 64: “The mandate continues to receive reports of the systematic use of forced interventions worldwide. Both this mandate and United Nations treaty bodies have established that involuntary treatment and other psychiatric interventions in health-care facilities are forms of torture and ill-treatment.79 Forced interventions, often wrongly justified by theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimised under national laws, and may enjoy wide public support as being in the alleged "best interest” of the person concerned. Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment (A/63/175, paras 38, 40, 41). Concern for the autonomy and dignity of persons with disabilities leads the Special Rapporteur to urge revision of domestic legislation allowing for forced interventions.”
The Special Rapporteur on Torture also commented on the “intimate link between forced medical interventions based on discrimination and the deprivation of legal capacity.” In the case of covert medication, ableist presumptions about the capacity of persons with mental health issues may drive the decision to covertly medicate.

Proponents of the practice may challenge that characterization and assert that the failure to covertly medicate could amount to the withholding of treatment. The UK’s Royal College commented on the application of Article 3 of the UK’s Human Rights Act (“No one shall be subject to torture or inhuman or degrading treatment or punishment”). They asserted, “repeated restraint and injection of treatment … may well be more degrading and inhuman than the covert administration of medication.” If a person is not covertly administered, that same medication might be used as a chemical restraint. The failure to covertly medicate may lead to the use of more coercive measures, like chemical or physical restraints.

6. Recognizing that We All Live in Society

The LCO’s final principle emphasizes the role of all individuals in their communities. It acknowledges that persons with disabilities – including persons with mental health issues - are members of society with entitlements and responsibilities to their families, communities and broader society. The CRPD’s Preamble emphasizes the importance of the recognition that persons with disabilities have duties to other individuals and to

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664 Special Rapporteur-Torture (2008), supra note 278.
666 Royal College UK (2004), supra note 330: “In an incapacitated adult, repeated restraint and injection of treatment (with attendant risk to life) may well be more degrading and inhuman than the covert administration of medication.”
667 LCO Framework (2012), supra note 63 at 88: “A principle that recognizes the various communities to which persons with disabilities belong may strengthen the recognition of difference and diversity and add further dimensions to the right to participation and inclusion. It may also provide a helpful means of articulating and analyzing tensions that may arise between the rights of persons with disabilities and those of other members of the community.”
the communities to which they belong. Research participants did not raise this principle explicitly, possibly because it was not related to any of the three clinical scenarios. Nevertheless, this principle could be understood as relevant to the right of persons with mental health issues to remain well in the community. Gostin (2009) emphasized that people cannot “fully engage in social interactions, participate in political process, exercise rights of citizenship, generate wealth, create art, and provide for common security” without minimum levels of health, further noting that public health encourages individual connectedness to the community.

iii) Procedural Rights and Accessibility of Review Processes

Law’s implementation is as important as its substance. Persons with disabilities require meaningful access to law, including complaint mechanisms to identify and resolve problems as well as proactive mechanisms like audits or institutional advocates. Such mechanisms are important “not only for addressing individual issues that may arise in the implementation of a program, but also for identifying and addressing systemic problems with a law or its implementation.” Indeed, LCO’s principles of “Fostering Autonomy and Independence” and “Promoting Social Inclusion and Participation” (above) require that the “systems that serve persons with disabilities can be understood and navigated by them, which requires provision of appropriate information and supports.”

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668 CRPD, supra note 108 at “Preamble”: “(w) Realizing that the individual, having duties to other individuals and to the community to which he or she belongs, is under a responsibility to strive for the promotion and observance of the rights recognized in the International Bill of Human Rights.”

669 Gostin (2008), supra note 34 at 8

670 Gostin (2008) supra note 34 at 18: “Viewing health risks as common to the group, rather than to specific individuals, helps foster a sense of collective responsibility.”

671 LCO Framework (2012), supra note 63 at 116

672 LCO Framework (2012), supra note 63 at 119: “No law, policy or program will operate perfectly: errors and problems will inevitably arise, and mechanisms must be put in place to identify and address these. Therefore, persons with disabilities require meaningful access to the law. Some laws rely on complaint mechanisms of various types to identify and resolve issues, while others use proactive mechanisms like audits or institutional advocates for this purpose, and others use a combination of mechanisms. This section applies the principles to complaint and enforcement mechanisms.”

673 LCO Framework (2012), supra note 63 at 119.

674 LCO Framework (2012), supra note 63 at 116. See also 3: “Laws may be positive on paper, but may fall
The covert administration of medication raises important questions about procedural fairness and natural justice. It is not clear whether the SDM must expressly consent to the concealment of medication. Ontario’s Superior Court in SMT v Abouelnasr found that the SDM impliedly consents to the application of physical restraints as part of the treatment package. It is unclear how this proposition would apply to a challenge about the concealment of medication in food or drink. If the SDM does not explicitly consent to the covert administration, it may be that neither the patient nor the SDM would be aware of the fact of the covert administration of medication. This means that neither patient nor the SDM would then be able to challenge the decision to covertly administer medication. In such cases, the decision to covertly administer the medication would be immune from review. There are other practical barriers to the litigation of claims related to covert medication, including the affordability and accessibility of legally-aided services:

Of course, it is doubtful that potential plaintiffs have ready access to legal representation, or the opportunity to obtain injunctive relief in the short space of time between the formulation of a treatment decision by the director of the medical-health facility and the administration of antipsychotic medication on the patient. It is questionable whether the patient would be similarly motivated -- or practically able -- to launch post facto proceedings.

Ontario’s Mental Health Act requires the documentation of application of physical and chemical restraints. There is, however, no such explicit requirement for the covert administration of medication. Without a notation on her Medical Administration Record or clinical chart, a patient and her SDM may never know that medication had been

675 SMT (2008), supra note 290.
676 Verdun-Jones & Lawrence (2013), supra note 192 at 522ff.
677 MHA, supra note 212 at s 53.
hidden in her food or drink. The Psychiatric Patient Advocacy Office commented on this scenario:

The very nature of this practice makes it difficult to challenge because medication is being administered without your knowledge.678

These questions of procedural fairness invoke Charter protections, specifically Section 7 ("Life, Liberty and Security of the Person"), Section 9 ("Right to not be Arbitrarily Detained or Imprisoned") and Section 10 ("Procedural Rights on Arrest or Detention").679 There are additional international protections680 including as expressed by the CRPD.681 In RM v St Andrew's Healthcare (2010), the UK's Upper Tribunal set aside the order of a lower tribunal to withhold information from the applicant about the delivery of covert medication during the proceeding. The UT drew on Article 6 of the European Convention on Human Rights ("Fair Trial") to find without disclosure of the fact that he was covertly medicated, any hearing would be "a mere mummery."682 The UK's Royal College also comments on the application of Article 6 of the UK's Human Rights Act ("Everyone is entitled to a fair and public hearing within a reasonable period of time by an independent and impartial tribunal established by law"). The Royal College found that it is “essential” that covert medication be clearly documented, so that “a fair and public hearing may be obtained if and when required.”683

iv) Applying the LCO Framework and Resolving Tensions

The LCO’s Framework aims to develop strategies for “addressing any identified

678 PPAO, supra note 15 at 4.
679 See section II.v (“Nature and Value of Rights”) below about emergent questions about the application of the Charter to the actions of hospitals.
681 CRPD, supra note 108 at Articles 13 ("Access to Justice") and 14 ("Liberty and Security of the Person.
shortfalls.” A fulsome application of the LCO’s multi-step approach - outlined in Chapter 2 (“Theoretical Frameworks”) - is beyond the scope of this section. This study does not answer the question of whether the covert administration of medication is justified or justifiable in law. Instead, it draws on the LCO’s Framework to offer a typology of legal principles to guide further analysis.

The LCO principles, above, cannot be neatly separated from each other. The LCO characterized substantive equality as an overarching aim, useful to resolve conflicts between other principles. The principles of the “Right to Live in Safety”, “Social Inclusion and Participation” and “Fostering Autonomy and Independence” interrelate, especially as they apply to mental health law in Ontario. The LCO illustrated tensions between these principles with the example of Community Treatment Orders (CTOs):

The principle of inclusion and participation is important, both in that the ability to transition to or remain in the broader community (as opposed to the hospital) is seen as an aspect of fostering autonomy and independence, and in the emphasis on involving the person with a disability, as much as possible, in the decisions about treatment orders. The principle is also linked to that of respecting the right to live in safety, as one focus of CTOs is on ensuring that persons with mental health disabilities are able to remain well enough to remain safely in the community. Further, the example highlights the importance of supports to enable autonomy and independence. A key context for CTOs is the difficulty of accessing community supports for some persons with mental health disabilities, and the role of CTOs in promoting access to those supports. As well, the concerns expressed about the potentially coercive nature of CTOs highlight the importance placed on ensuring meaningful choices for persons with disabilities.

The LCO illustrated the tensions between principles in the context of Ontario’s law about

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685 LCO Framework (2012), supra note 63 at 94.
686 LCO Framework (2012), supra note 63 at 8: “This goal of achieving substantive equality for persons with disabilities has been articulated in many important legal and policy documents, including the United Nations Convention on the Rights of Persons with Disabilities, the Canadian Charter of Rights and Freedoms, the Ontario Human Rights Code and In Unison.”
687 LCO Framework (2012), supra note 63 at 112.
688 LCO Framework (2012), supra note 63 at 82.
capacity:

On the one hand, some see these laws as a careful balance between the security and autonomy of persons with disabilities, which, if properly implemented can promote the well-being of persons with diminished legal capacity. On the other hand, many persons with disabilities have long raised concerns about the assumptions that underlie both the substance and the implementation of the law...Many persons with disabilities, particularly those with intellectual disabilities, have therefore advocated for a shift to a system of “supported decision-making” as advancing these two principles by better reflecting the manner in which people make and communicate decisions, as well as empowering persons with disabilities in fundamental aspects of their lives.689

It may be that satisfying one principle (such as “Fostering Autonomy and Independence”, above) threatens the realization of other principles (including “Facilitating the Right to Live in Safety”, above). In its Policy on Competing Human Rights, the Ontario Human Rights Commission (OHRC) emphasized early resolution of these conflicts and offers a tool to analyze and reconcile competing rights. The OHRC asserted, “no rights are absolute and no one right is more important than another right.”690 The LCO also offered a strategy for addressing tensions between principles:

a. Whether there are broader contextual issues (such as a lack of appropriate resources) causing the tensions between principles, and if so, whether these issues can be addressed to resolve the tension?
b. Whether there are approaches to the issue that will permit either complete or at least partial achievement of both competing principles?
c. Which of the potential approaches will best advance substantive equality for persons with disabilities?
d. Have persons with disabilities been consulted in determining how to resolve the tensions?691

689 LCO Framework (2012), supra note 63 at 111: “As Michael Bach and Lana Kerzner outline, the law is believed by some to embody presumptions about the abilities of persons with intellectual or cognitive disabilities that are based on unexamined assumptions and undermine their recognition as full persons, thereby undermining the principle of dignity and worth.”
691 LCO Framework (2012), supra note 63 at 111.
In the case of covert medication, it may be that policy and resourcing decisions lead to a lack of supports and resources in inpatient psychiatric settings. Staff may not be able to devote time to explore alternative ways to support patients to make their own capable decisions. It may be that there are few other supports, besides medication management, available to inpatients. Medication management is one of a few items on the menu of services available. The LCO expanded on tensions between autonomy and security, as relevant to access community-based mental health supports and services:

In such a case, the real issue may not be a tension between the principles of autonomy and security, but the impact on both principles of the limited available appropriate resources to maximize both. That is, we should not be too quick to reduce a challenge or difficulty to an instance of tensions between the principles.\(^\text{692}\)

The covert administration of medication should be an intervention of last resort and used only when all possible alternative interventions (including “health teaching” as described by nurse-participants in the focus group) are exhausted. The UK’s Royal College of Psychiatrists’ Statement on Covert Administration of Medicines requires that “all efforts must be made to give medication openly in its normal tablet or syrup form.”\(^\text{693}\) The CAMH policy provides that “covert administration of medication is a permissible therapeutic option only if and when it has been determined by the relevant inter-professional team and SDM to be justified as preferable to other available therapeutic options.”\(^\text{694}\) For instance, the person may consent to the medication when asked by another HCP.

The principle of “least restraint” may require that HCPs speak with the person to consider why she is refusing the medication. It may be that the person is resisting because of the colour of the pill or its perceived side effects, which may be resolved by a

\(^{692}\) LCO Framework (2012), supra note 63 at 95 [emphasis added].

\(^{693}\) Royal College UK (2004), supra note 330 at 2: “All efforts must be made to give medication openly in its normal tablet or syrup form.”

\(^{694}\) Centre for Addiction and Mental Health (CAMH), Covert Administration of Medication (PC 2.3.3) (December 2012) [emphasis added].
prescription change. The UN’s MI Principles provide that patients have a right to the least restrictive or intrusive treatment.\textsuperscript{695} Ontario’s \textit{Patient Restraints Minimization Act} (PRMA) states as its purpose to “minimize the use of restraints on patients and to encourage hospitals and facilities to use alternative methods.”\textsuperscript{696} The PRMA requires that institutions develop training and policies that offer alternatives to the use of restraints.\textsuperscript{697} With respect to covert medication, psychiatric settings should consider the development and delivery of training that focuses on the identification and minimization of triggers, as well as other strategies, that avoid the covert administration of medication.

\textbf{v) Nature and Value of Rights, including Limitations of their Application}

This research has gone beyond an uncritical description of different understandings of a controversial practice. It sets the stage for further examination and contextualization of the meaning of rights in psychiatric settings, especially in an on-the-ground sense. As set out in Chapter 2 (“Theoretical Frameworks”), this research applied a critical rights framework to explore how the law is expressed, in an everyday sense, for persons involved in the psychiatric system. This is a different starting point than “what is the law?”\textsuperscript{698}

Focus group and interview participants appeared to understand that the practice has something to do with “rights”. The document analysis also revealed many references to the language of law and rights. For instance, the CAMH Policy refers to the HCCA. The

\begin{footnotesize}
\begin{itemize}
\item[\textsuperscript{695}] MI Principles, \textit{supra} note 253 at Principle 9.1: “Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient’s health needs and the need to protect the physical safety of others.”
\item[\textsuperscript{696}] \textit{Patient Restraint Minimization Act}, RSO 2001, c16 [PMRA]. Section 2.2 provides that the PMRA does not apply to persons involuntarily detained at psychiatric facilities.
\item[\textsuperscript{697}] PRMA, \textit{supra} note 696 at s 7.
\item[\textsuperscript{698}] Macaulay (2005), \textit{supra} note 147. See also LCO Framework (2012), \textit{supra} note 63 at 94: “In many cases, however, the law is sound on paper, but problematic in practice. Laws, policies and practices that are in theory neutral or even intended to benefit persons with disabilities may fall short of their goal or have unintended negative consequences.”
\end{itemize}
\end{footnotesize}

There were different questions raised about the will of HCPs, SDMs and institutions to implement and give life to these rights. One interview participant emphasized that the HCCA is great theoretically, but not in practice. According to one legal-participant, “People never realize their rights.” To long-acknowledged “legal realist” accounts, this disconnect is described as the difference between law-on-the-books and law-in-action. The rights of people with mental health issues are not applied or enforced on the

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699 Royal College UK (2004), supra note 330: “We are not aware of any test case under the Human Rights Act 1998 of the practice of administering medication covertly. The following articles of the Human Rights Act seem particularly relevant: Article 2 ‘Everyone’s right to life shall be protected by law’; Article 3 ‘No one shall be subject to torture or inhuman or degrading treatment or punishment’; Article 5 ‘Everyone has the right to liberty and security of person’; Article 6 ‘Everyone is entitled to a fair and public hearing within a reasonable period of time by an independent and impartial tribunal established by law’; Article 8 ‘Everyone has the right to respect for his private and family life, his home, and his correspondence’.”

700 Mental Welfare Commission for Scotland (2013), supra note 333 at 2ffe: “Under the law in Scotland, there are mechanisms for giving medical treatment to people who lack capacity. The two significant pieces of legislation are: The Adults with Incapacity (Scotland) Act 2000 (“the 2000 Act”). The Mental Health (Care and Treatment) (Scotland) Act 2003 (“the 2003 Act”). [...] Despite these two new Acts, the legal basis for giving covert medication is unclear.”

701 Scotland, Adults with Incapacity (Scotland) Act 2000: Code of Practice (Third Edition): For Practitioners Authorised to Carry Out Medical Treatment or Research Under Part 5 of the Act (SG/2010/57), online: Scotland <http://www.scotland.gov.uk/Publications/2010/10/20153801/10 > at 2.60: “The use of covert medication is permissible in certain, limited circumstances e.g. to safeguard the health of an adult who is unable to consent to the treatment in question, where other alternatives have been explored and none are practicable. Healthcare staff should not give medication except in accordance with the law, and even where the law allows its use it should not be given in a disguised form unless the adult has refused and their health is at risk because of this. Staff are obliged to record this in the patient’s records. Practitioners who may be requested to administer covert medication should make themselves fully aware of the guidance of their own professional bodies. It may also be helpful to refer to the Mental Welfare Commission Scotland’s guidance documents Consent to Treatment and Covert Medication - a legal and practical guide.”

702 Nursing Midwifery Council (2013), supra note 336.
ground. The dissonance between law-on-the-books and law in action is also the subject of mental disability law scholarship. In particular, Patton (2008) asserted that Ontario’s Mental Health Act’s significant protections are “often neglected or intentionally avoided in the day-to-day operation of hospitals.” Bay (2006) pointed to examples of Ontario’s routine failure to enforce legal protections owed to persons involved in the psychiatric system.

If the SDM is not required to consent to concealment, it may be that no one would have information needed to challenge the decision to covertly administer medication. Without access to a barrier-free system of enforcement, these “rights” are reserved for the privileged few. Inpatients experience additional barriers to accessing legal advocacy. One legal-participant wondered if the subject of one scenario would have access to

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703 Michael Perlin, “International Human Rights and Comparative Mental Disability Law: The Role of Institutional Psychiatry in the Suppression of Political Dissent” (2006) 39 Israel Law Review 69 at 85: “The dichotomy between “law on the books” and "law in action" dichotomy is a gap that has plagued American mental disability law since it began. Cases are decided on the Supreme Court level, yet are not implemented in the states.”

704 Perlin (1999), supra note 153 at 19-20: “This invisibility means that the most important aspects of mental disability law- not just the law “on the books,” but, more importantly, the law in action and practice-remains hidden from the public discussions about mental disability law. [...] There is a wide gap between law-on-the-books and law-in-action. There is probably such a gap in every area of the law. But here, the omnipresence of sanism and pretextuality make the gap even more problematic.”

705 Lora Patton, “These Regulations Aren’t Just Here to Annoy You: The Myth of Statutory Safeguards, Patient Rights and Charter Values in Ontario’s Mental Health System” (2008) 25 WRLSI 9 at 29: “Despite the significant protections outlined in the MHA, those protections are often neglected or intentionally avoided in the day-to-day operation of hospitals. Put another way, “there is a wide gap between law on the books and law-in-action” [cited to Perlin (1999), supra note 9] and the “law-in-action” is the understanding of physicians and the experiences of patients. The law becomes what is practiced, what is allowed to occur and what goes without remedy.”

706 Michael Bay, “Making the Law Match the Reality: Making the Reality Match the Law” (2006) 1:1 J Ethics in Mental Health at 4: “In fact, I would argue that it would be better in many ways not to have any laws at all in these areas than to have laws that are ignored. At least, if we had no laws, we would know that we have not legislated and not fulfilled our responsibility. The way it is right now, we can dupe ourselves into thinking that we have dealt with the issue and solved the problem when, in reality, we have done nothing of the kind. I think that there is something profoundly frightening in a state of affairs wherein we pass legislation in the glare of publicity but then ignore it or violate it away from the bright lights when dealing with our most vulnerable citizens who rely on the legislation to protect their rights.”

counsel. Specific to covert medication, Scotland’s Mental Welfare Commission called for improved access to independent advocacy to help to determine the patient’s present views, including considering what the person may have said to relatives or friends in the past.\footnote{Mental Welfare Commission for Scotland (2013), \textit{supra} note 333.}

In the case of covert medication, the law does not have clear or specific effect. The spirit of legal protections may be superficially invoked to support, reject or qualify it. This result is reminiscent of critical accounts of the law, which abound with references to the everyday (in)determinacy of the law.\footnote{McEvoy (2005), \textit{supra} note 165 at 442-3: “We can, then, identify an emergent body of scholarship in legal studies that we can usefully designate New Legal Realism. [...] Authors in this mode characteristically analyze law as it works in reciprocal interaction with adjacent realms of social experience. The environment in which they situate their analysis is in an active, causally potent one. Legal consciousness suffuses that environment, organizing people’s thought, their behavior, and their culture.”} This is also a concern of New Legal Realism (NLR).\footnote{Miles & Sunstein (2008), \textit{supra} note 164 at 11.} Covert medication is an example of a controversial practice that supports confusion and institutional silence. For such practices, the law is difficult to apply, or there may be a reluctance to determine how to apply legal principles. In particular, Patton (2008) pointed to the failure to implement \textit{Charter} values in the day-to-day operation of psychiatric settings:

\begin{quote}
While \textit{Charter} values have been imported into our written law, the Ontario mental health system has not incorporated those values into the law as it is acted out within psychiatric facilities.\footnote{Patton (2008), \textit{supra} note 705 at 11: “Legal rights however, are not only dependent on written law. The enforcement of legislation, or the choice not to do so, has a much more profound effect on individuals than the words contained in a statute. Where the state fails to provide meaning to the checks and balances of the MHA, the benefit of having a stated "right" is lost. While Charter values have been imported into our written law, the Ontario mental health system has not incorporated those values into the law as it is acted out within psychiatric facilities.”}
\end{quote}

The covert administration of medication raises questions about the application of the law at the outer-edges of psychiatric practice. The controversy surrounding the covert administration of medication may reflect discomfort about disputes at the outer edges of capacity and consent. Covert administration is situated within a grey area: a person is
indefatigable of making treatment decision but is also “treatment incompetent”. Is it that the “treatment incompliance” causes us to second-guess the validity of the “incapacity” determination? If a person so heartily refuses medication, does it suggest that there is at least some level of capacity – the capacity to express her (incapable) wish to refuse medication? Or is it that the treatment resistance somehow suggests her deep-down (capable) wishes? This discomfort may be especially conspicuous where the person determined to be incapable experiences an episodic disability as in the case of some types of mental health issues.

It may be that the law has trouble understanding these blurred lines and defaults to the more powerful interests, reproducing inequality. In contested areas of the law, the political is most likely to win.712 This may be especially so where conflicting rights are engaged, as in the case of covert medication. The law works to reinforce power structures. Silbey (2005) considered how the “law sustains its institutional power despite a persistent gap between law on the books and law in action.”713

Further research will address the value of law reform advocacy that draws on the Charter and international legal arguments. The focus group or interview participants did not expressly invoke the Charter. However, the Charter complements and underlies most of the rights set out in Section III.ii (“Review of Relevant Legal Principles”), above. Paramount over legislation, the Charter is the “supreme law of Canada.”714 Despite its fundamental importance, there are unanswered questions about the application of the Charter to decisions made by HCPs in hospital settings715 (e.g., the decision to covertly administer medication). There are emergent questions about the utility of the Charter to advance the claims of persons who are covertly medicated. Answers likely depend on

712 Miles & Sunstein (2008), supra note 164 at 11: “We are speaking, moreover, of the most contested areas of the law, where political differences are most likely to break out—and also of appellate cases, where the legal materials are likely to have a degree of indeterminacy.”
713 Silbey (2005), supra note 168 at 323: “Why do people acquiesce to a legal system that, despite its promises of equal treatment, systematically reproduces inequality?”
714 Charter, supra note 105 at s 52.
715 Patton (2008), supra note 705.
whether the claim impugns the (in)actions of an HCP or a hospital. The Charter governs the action of government entities as well as entities implementing government policies or programs.\textsuperscript{716} In \textit{Stoffman v Vancouver General Hospital}, the Supreme Court of Canada held that the Charter does not apply to the day-to-day operations of hospitals.\textsuperscript{717} In \textit{Eldridge v British Columbia (Attorney General)}, the Supreme Court of Canada found that the Charter applied to the hospital’s decision to not provide sign language interpretation services to patients.\textsuperscript{718} \textit{Chaoulli} suggests that the Charter does apply to the provision and funding of health services.\textsuperscript{719} In \textit{Rasouli v Sunnybrook Health Sciences Centre}, Ontario’s Superior Court excluded the actions of individual doctors from the Charter’s reach. In particular, Justice Himel considered the Supreme Court’s decision in \textit{Eldridge}:

> A doctor’s status as an independent contractor owing an individual duty of care to a patient is such that the doctor may not be considered a government agent in the same manner as a hospital as determined in \textit{Eldridge}.\textsuperscript{720}

Legal scholarship reflects the case law’s ambiguity. Monticone (2000) considered the proposition that the application of restraints by a hospital or LTC facility does not amount to “government action.”\textsuperscript{721} The relationship between the government and the use of restraints is close enough to qualify as a “government action” subject to the Charter.\textsuperscript{722} Though not about covert medication or restraints, Jackman (2001) proposed that \textit{Eldridge} “recognizes that this important area of government activity should be subject to Charter review.”\textsuperscript{723} Despite the influence of \textit{R v Swain}, \textit{Fleming v Reid} and

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\textsuperscript{716} \textit{McKinney v University of Guelph}, [1990] 3 SCR 229 (Lexum).

\textsuperscript{717} \textit{Stoffman v Vancouver General Hospital}, [1990] 3 SCR 483 (Lexum).

\textsuperscript{718} \textit{Eldridge v British Columbia (Attorney General)}, [1997] 3 SCR 624 (Lexum). However, the Supreme Court did not expressly consider whether the Charter applies to the decisions of individual doctors.


\textsuperscript{720} \textit{Rasouli v Sunnybrook Health Sciences Centre}, 2011 ONSC 1500, [2011] OJ No 1100, 105 OR (3d) 761 (QL) (Sup Ct) at paras 85-92. On appeal, neither the Court of Appeal nor the Supreme Court considered the Charter’s application.


\textsuperscript{722} Monticone, \textit{supra} note 721.

Starson v Swayze, Kaiser (2009) considered the disappointments of the post-Charter era:

Canadians with mental health problems will remain at best ambivalent about the role of the Charter. Despite the gains associated with a handful of major cases, there have been many rollbacks. Although some decisions seem to have provided a basis for limited confidence that individual autonomy would no longer be as susceptible to the easy erosion of the pre-Charter era, the new tide of more extensive statutory bases for intrusion and their concomitant lowered thresholds belies these apparent victories. The Charter is not a reliable foundation for the reversal of the contemporary coercive wave or the promotion of equality promoting statutory supplements.724

The Document Analysis and the Literature Review revealed few details about the application of international law to the covert administration of medication. This may be because the CRPD only entered into force in 2008.725 Additionally, scholars have noted the relative weakness of the international system to ensure compliance in the area of social and economic rights. Gostin (2008) pointed out that international human rights law seldom provides “easy answers”.726 Bartlett (2012) argued that the CRPD does not “reflect the current reality in which people with mental disabilities live”727, and that the CRPD is “not entirely clear what it requires” including with respect to supported decision-making models.728 Nevertheless, the CRPD may be useful to strengthen or support other arguments relevant to the covert administration of medication.

725 CRPD, supra note 108.
726 Gostin (2010), supra note 69 at 259: “International human rights law seldom provides easy answers; rather, the field struggles to define and enforce human rights in the context of the legitimate powers of governments and the needs of communities.”
728 Peter Bartlett, “The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law” (2012) Modern Law Rev 752. See also Bartlett, supra note 727: “At times, it seems to preclude any form of decision-making on behalf of others (Art 12(2)), but at other points, it is more ambiguous (Art 12(4)). Additionally, there is the broad interpretive question of the extent to which the CRPD provides new rights (clearly sometimes yes – eg., Art 17), and how far it instead is intended to ensure the equal application of existing rights to people with disabilities (and what, precisely, that means)."
IV. Further Research

This section offers examples of meaningful and innovative opportunities to advance the research agenda in this area. It is remarkable that such a divisive topic has not been studied empirically to any great degree. The absence of research data suggests that it is not an evidence-based practice.

For instance, evidence is required to determine the prevalence and the distribution of the practice of covert administration of medication in Canada. This research was not designed to gather information about if or how often the practice occurs in psychiatric settings. Instead, the research aimed to gather contextual detail about the practice in order to guide further research.

Additional research may explore the practice in long-term care settings. In particular, additional research should consider the influence of the Resident's Bill of Rights, set out in the Long Term Care Homes Act, which includes specific protections against abuse and neglect.729

Further research may explore the practice's contexts and impacts for persons in psychiatric settings from racialized communities. Perceptions of the practice's impact on patients' rights-situations may be grounded in its cultural context(s). While the scenarios were developed to reflect the diversity of Ontario’s patient populations, participants did not often raise the impact of race and culture. Nevertheless, scholarship has raised questions about the universlity of human rights obligations in psychiatric practice.730

Drawing from the research findings, future research should attempt clarification on the

729 LTCHA, supra note 27.
730 Latha (2010), supra note 142; Hanlon et al (2010), supra note 143.
following issues:

- What are the underlying structures of the covert administration of medication in specific patient populations, including persons diagnosed with acquired brain injury, dementia and developmental disabilities?
- How do workplace pressures drive HCPs’ decision to covertly administer medication? Is medication more frequently covertly administered during night shifts, when the staff complement is usually lower?
- Are patients with mental health issues more likely to be covertly medicated than patients with other capacity issues?
- What are the specific legal issues that arise from the covert administration of medication in emergency room settings?
- How does the practice vary in urban, suburban and rural settings?
- How can population-level interventions support the recovery of people who return to their communities from inpatient psychiatric setting where medication was covertly administered?

Understanding the practice of the covert administration of medication requires an interdisciplinary approach. There are challenges – including translational barriers - in working across the fields of law and medicine. Future research may consider the involvement of multiple stakeholders in developing effective knowledge exchange plans.

V. LIMITATIONS

This research is limited by its sample size. There were very few documents available for the document review and document analysis. Participant recruitment was also challenging, given limitations on potential participants’ schedules. However, the researcher was able to delve deeply into participants’ responses because of the few participants in each of the three focus groups.

The results are not easily generalizable to jurisdictions outside of Ontario. Given that the
laws that govern consent and capacity are within the provincial jurisdiction, this study focused on its practice in Ontario. The legislation in British Columbia is different: it links treatment incapacity with involuntary admission to psychiatric settings. Like other qualitative research, the study purpose was not to develop findings that could apply to a wider population or to different contexts. Instead, this exploratory research aimed to dig deeply into the data, offer thick description of participants’ responses and set the stage for follow up research.

As set out Chapter 5 (“Methodology”), no one who identified as a patient or ex-patient participated in this research. Given research ethical concerns about patients’ participation, their voices could not be directly included. Indeed, patients and ex-patients may not be aware that medication was delivered to them in their food or drink as, the fact of the covert administration of medication may not be revealed to patients during their inpatient stay or after discharge. This limitation should be rectified by their inclusion in policy and law reform efforts. The voice of consumers-survivors, clients, ex-patients and patient advocates must be included to ensure that any efforts aimed at maximizing patient dignity have an on-the-ground impact.

VI. Conclusion

This chapter drew linkages between the data, the literature and the experience of “doing the research.” It aimed to tell the story of the research. It also set the stage for further conversation about the development of better practices and the identification of areas for further debate, research and discussion.

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731 Schizophrenia Society of Ontario, *It Doesn’t Work: Unpacking Mental Health Policy and Legislation* (Toronto: SSO, 2013), online: SSO <schizophrenia.on.ca/getmedia/e90d8303-6799-441f-ba11-3b76423997b0/It-Doesn-t-Work-one-page-up,-no-bleed.pdf.aspx> at 17: “In some other provinces, for example, British Columbia, a more rigorous form of involuntary or non-consensual treatment exists, as treatment can be administered to someone based solely on their status as an involuntary patient – regardless of whether s/he is capable of consenting to treatment decisions, or what a substitute decision-maker expresses on his or her behalf.”

This research drew on the “twin” fields of public health and human rights\textsuperscript{733} to explore the impact of the practice of the covert administration of medication on patients’ rights-experience and its underlying socio-political-legal structures. As set out in Chapter 1 ("Introduction"), this research raised critical questions at the intersection of public health and human rights, including the authority of the state (and its actors) to constrain an individual’s autonomy to accept or reject treatment. It considered the vulnerability of people with mental health issues to exclusion, marginalization and loss of dignity. It drew on the literature about public health’s underlying social justice foundations\textsuperscript{734}, including the “inextricable” link between human rights and health, including mental health\textsuperscript{735} While discrimination and coercion are outside the traditional purview of public health, the field of modern public health is interested in the equitable distribution of social and economic resources\textsuperscript{736}

By focusing on the policies and laws that govern the practice, this research does not focus on the experience at the individual level. Instead, this research emphasizes the systematic and contextual structures that determine and influence the decision to covertly medicate. This macro-level focus is characteristic of the study of public health in that it is so often concerned with broad strategies (including law or legal practice) to ameliorate disadvantage and promote wellbeing.

\textsuperscript{733} Gostin & Madison (2006), \textit{supra} note 65 at 1054: “Our account of justice stresses the fair disbursement of common advantages and the sharing of common burdens. It captures the twin moral impulses that animate public health: to advance human well-being by improving health and to do so by focusing on the needs of the most disadvantaged. [...] These two aspects of justice – health improvement for the population and fair treatment of the disadvantaged - create a richer understanding of public health.”

\textsuperscript{734} Faden & Powers (2008), \textit{supra} note 66 at 151: “Health is one of these distinct dimensions of well-being, as is personal security, the development and exercise of cognitive capacities for reasoning, living under conditions of social respect, developing and sustaining deep personal attachments, and being able to lead self determining lives.”

\textsuperscript{735} Faden & Powers (2011), \textit{supra} note 71 at 598: “For us, public health and biomedical science policies draw their foundational legitimacy—their ultimate justificatory structure—from the essential and direct role that health plays in human well-being, the primary object of social justice.” See also Gostin (2001), \textit{supra} note 137 at 266: “... mental health and human rights are inextricably linked.”

\textsuperscript{736} Gostin & Powers (2006), \textit{supra} note 65 at 1055: “Fairness requires just distributions of burdens and benefits to all, but also procedural due process for people subjected to compulsory interventions.”
As set out in Chapter 6 ("Results"), few institutional policies, clinical protocols or practice guidelines govern the covert administration of medication in Ontario's psychiatric settings. According to the two available policies, the practice may not be considered for patients who are capable of giving consent, and the SDM must explicitly consent to the concealment. There are additional, unanswered questions about the professional responsibility of HCPs involved in the covert administration of medication.

The research considered the practice's impact on patients' rights experience. The practice impairs access to knowledge by patients, SDMs and HCPs. In particular, the covert administration of medication precludes the patient (and possibly the SDM) from participating in treatment decision-making. Without their participation, HCPs may not have access to information about side effects and underlying reasons for medication refusal. The practice may interfere with the therapeutic relationship between the patient and the HCP. Questions were raised about how the practice impacts patients' best interests, including patient recovery. Covert medication can also be characterized as “autonomy restoring” since it assists a patient in making her own capable decisions after a few doses. On the other hand, the practice may interfere with a patient’s meaningful recovery as she moves from hospital to the community without knowledge of the fact of the covert medication.

This research also explored the structures that maintain the practice of the covert administration of medication. As expressed in Chapter 6 ("Results"), an understanding of capacity - as an “either/or” construct, - underlies the practice. This all-or-nothing approach is to be distinguished from an approach that imagined capacity as being able to be fostered with support. The decision to covertly administer medication may be driven by stereotypes about persons with capacity issues. Consistent with participant responses, the invisibility of the practice of covert medication is reflective of the experience of marginalization faced by persons with mental health issues. The practice of the covert administration of medication relies on a faith that medication will be effective; it also relies on deference to medical decision-making. Research findings suggest that confusion and institutional silences also underlie and reinforce the practice.
In broad terms, this research concluded that the covert administration of medication is contextually driven. It is an incident of and maintained by the larger psychiatric system. Covert medication practice is also an example of law’s indeterminacy in psychiatric settings in Ontario. Covert medication is understood to have “something to do” with rights. There is, however, confusion about how those rights play out in the case of covert medication. For such controversial practices, about which there are institutional silences, the law is difficult to apply, or there is a reluctance to figure out how to apply legal protections. Covert medication reflects and is supported by an inflexible approach to the determination of treatment incapacity. It is primarily concerned with the management of “risky” inpatients in the short-term.

Like other public health research, this study contemplated broad-based interventions to improve the well-being of members of marginalized communities, including the development of effective and appropriate approaches to treatment non-adherence that maximize patient dignity. This research identified legal issues raised by the practice in order to support the development of better practices about the covert administration of medication in psychiatric settings. The development of a strong policy environment is key to resolving the confusion, discomfort, silences and tension that characterize the covert administration of medication. The use of the term “better practice” - rather than “best practice” - is intentional as policy-makers may determine that the covert administration of medication may never amount to a best practice. To ensure practices are sensitive to the real-world impact of the practice on patient’s dignity and wellbeing, policy development must include the voice(s) of patients, ex-patients and patient-advocates.

A dissemination plan will be built to optimize responsible knowledge exchange and support the development of better practices. Partnerships will be developed with organizations that represent the interests of HCPs, psychiatric institutions, government, patients and patient advocates as well as community and advocacy organizations. Particular attention will be paid to the identification of stakeholders who represent the
interests of persons with mental health issues from racialized and indigenous communities. The knowledge exchange plan may include grand rounds, discussion panels at conferences and community-based meetings. To engage stakeholders in a useful discussion, broad principles of better practice will be drafted, informed by this research's focus on patients' rights-experiences. These broad principles will provide a springboard for further open debate, research and discussion. Stakeholders may be asked to consider the value of litigation strategies as well as systemic advocacy efforts that emphasize improved access to high-quality community-based mental health supports and services. An effectively resourced mental health system (with a range of treatment choices available in the community) promises that persons with mental health issues have a better chance of remaining well in the community, without need for long-term inpatient stays. Stakeholders may also consider efforts to protect and strengthen independent rights-advice to meet the advocacy needs of persons with mental health issues.

Most pressing, this research concludes that the covert administration of medication warrants overt discussion. It deserves careful analysis, foresight and attention to the development of adequate safeguards of rights, recovery and wellbeing.
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## APPENDICES

### APPENDIX A: PSYCHIATRIC SETTINGS CONTACTED

<table>
<thead>
<tr>
<th>Location</th>
<th>Description</th>
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<tbody>
<tr>
<td>Ajax</td>
<td>- Rouge Valley Health System - Ajax and Pickering Health Centre Site</td>
</tr>
<tr>
<td>Barrie</td>
<td>- Royal Victoria Regional Health Centre</td>
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<tr>
<td>Belleville</td>
<td>- Quinte Healthcare Corporation - Belleville General</td>
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<tr>
<td>Brampton</td>
<td>- William Osler Health Centre – Brampton Civic Hospital</td>
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<td></td>
<td>- Brampton Hospital Campus</td>
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<td>Brantford</td>
<td>- The Brantford General Hospital</td>
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<tr>
<td>Brockville</td>
<td>- Brockville General Hospital - Charles Street Site, Elmgrove Site and</td>
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<td>Garden Street Site.</td>
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<tr>
<td>Burlington</td>
<td>- Joseph Brant Memorial Hospital</td>
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<tr>
<td>Chatham</td>
<td>- The Public General Hospital Society of Chatham</td>
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<td>- Cornwall General Hospital</td>
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<tr>
<td>Goderich</td>
<td>- Alexandra Marine and General Hospital</td>
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<tr>
<td>Guelph</td>
<td>- Homewood Health Centre Inc.</td>
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<td>Hamilton</td>
<td>- Hamilton Health Sciences Corporation – (Hamilton General Hospital Site,</td>
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<td></td>
<td>Chedoke Hospital Site, McMaster University Medical Centre Site,</td>
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<td></td>
<td>Henderson General Hospital Site)</td>
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<td>Kenora</td>
<td>- Lake of the Woods District Hospital</td>
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<td>Kingston</td>
<td>- Religious Hospitallers of Saint Joseph of the Hotel Dieu of Kingston</td>
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<td>- Kingston General Hospital</td>
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<tr>
<td></td>
<td>- Kingston - Kingston Penitentiary, Regional Treatment Centre</td>
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<td>(*excluded since recently closed)</td>
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<td>Kingston</td>
<td>- Providence Care Centre: Mental Health Services Site</td>
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<td>Kitchener</td>
<td>- Grand River Hospital Corporation - Kitchener-Waterloo Site</td>
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<td>Grand River Hospital Corporation</td>
<td>- Freeport Site</td>
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<td>Lindsay</td>
<td>- Ross Memorial Hospital</td>
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<td>London</td>
<td>- St. Joseph’s Health Care, London</td>
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<td>- London Health Sciences Centre - University Campus, Victoria Campus</td>
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<td>Markham</td>
<td>- Markham Stouffville Hospital</td>
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<td>Mississauga</td>
<td>- Credit Valley Hospital and Trillium Health Centre - Credit Valley Site</td>
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<td>- Credit Valley Hospital and Trillium Health Centre - Trillium</td>
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<td>- Mississauga Site</td>
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<td>Newmarket</td>
<td>- Southlake Regional Health Centre</td>
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<td>Niagara Falls</td>
<td>- Niagara Health System - Greater Niagara General Hospital</td>
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<tr>
<td>Northeast</td>
<td>- Mental Health Centre - North Bay Campus</td>
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<td>(*excluded since merged with North Bay Regional Health Centre)</td>
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<td>Royal Ottawa Mental Health Centre</td>
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<td>Ottawa</td>
<td>Queensway Carleton Hospital</td>
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<td>Ottawa</td>
<td>Regional Children’s Centre Royal Ottawa Hospital, a division of the Royal Ottawa Health Care Group</td>
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<td>The Ottawa Hospital - Civic Campus, General Campus</td>
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<td>Woodstock - Woodstock General Hospital</td>
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APPENDIX B: TOPIC GUIDE

Thank you so much for speaking with me today. I hope that we can have a conversation about medication administration practices and how issues of medication administration relate to your (life) (work) (practice).

I am really interested in a situation where a patient/client is incapable of making a treatment decision but also refuses or resists medication. I am interested in your experiences and your thoughts about putting medication in patient food or drink in cases were individuals are not capable of making decisions about treatment.

There are some laws, policies and guidelines that might guide this practice, but because it is such a difficult area of practice, it is hard to know how covert medication policies work on the ground. I’d like to talk about how such laws, policies and guidelines play out in your (life) (work) (practice). To do this, I will provide some scenarios that may come up in your (life) (practice) (work).

I really want to hear your views, so please make sure that you ask for clarification if anything I say doesn’t make sense, or if I use any terms that you aren’t familiar with. Please don’t disclose any personal or confidential information.

As you know, I’ll be recording these conversations.

Please remember that this is meant to be a conversation. When deciding to put together a focus group, we hoped that it would serve as an opportunity to “bounce ideas” off each other. Please do so respectfully. If you disagree with something that someone says, please give the speaker a chance to finish. I’ll be keeping a speakers list.

I will keep details here in confidence, but I do strongly recommend that you do not use specific names, including of (patients’) (clients’) names.

Finally, I am interested in what YOU have to say; there are no right or wrong answers. This is not an evaluative exercise. I am just trying to understand the practice more generally.

I’ll get started, unless you have any questions about the process.

I will be presenting three Clinical Case Scenarios to you today. These scenarios were developed with the assistance of post-graduate medical students at the University of Toronto.

The scenarios are provided in written format in your packages. I have included bullet points here:
What is your reaction to this scenario? Does it “feel right” to you? What about it doesn’t feel right?

How come this happened? Why do you think this happened?

How do you think that things might have been different? What were some alternatives open to the (nurse) (doctor)?

Is this good practice? Is this “excellent” practice?

Is this scenario familiar to you in your work?

Do you think that he or she could have drawn on laws, policies or practice guidelines? What are the legal implications? (Probe if they don’t bring it up on their own.)

(LATER) How is this scenario different from the other two scenarios?

ANY OTHER QUESTIONS?

Is there something that we haven’t talked about that you’d like to say? Or something that you’d like to emphasize?

I have included, in your packages, note cards on which you can record an anonymous question. If you don’t get a chance to say what you want during this focus group, please write it down on this card, and leave in the box near the exit.
APPENDIX C: SCENARIOS

Scenario 1

- Manhor is 58 years old. Until recently, he had been living at home with his wife.
- Manhor has been treated for depression for many years, for which his physician has prescribed fluoxetine, in tablet form.
- Over the years, Manhor appeared to tolerate fluoxetine well.
- He was, however, admitted to a psychiatric facility and has been found incapable of making treatment decisions. His substitute decision maker is his wife, Nadira.
- Upset with the move, Manhor has consistently refused medications. When asked to take the tablets he gets agitated and pushes the nurses away.
- The nurses at the facility approached Nadira and asked for her permission to conceal medication in Manhor’s juice. Nadira pointed out that when he was living at home, she would crush the tablets into his tea. She also said that Manhor is less likely to finish his juice than he is to finish chai tea.
- Fluoxetine is available in liquid form.
- The doctor at the psychiatric facility wrote a new order for fluoxetine in liquid form.
- The nurses administered the liquid fluoxetine in Manhor’s tea.

Scenario 2

- Chenglei is 29 years old. He has previously been diagnosed with bipolar disorder.
- Chenglei had been prescribed lithium. Lithium alleviates some of his symptoms. Chenglei finds the side effects (including nausea and hair loss) to be intolerable.
- Chenglei has periods where he has been deemed decisionally capable, and other periods where he has been deemed incapable. When Chenglei is incapable of making treatment decisions, his father is his substitute decision maker.
- Chenglei stopped taking lithium because of side effects. He started to experience feelings of increased euphoria and insomnia. He engaged in risky behaviour, including driving into oncoming traffic.
- Chenglei was involuntarily admitted to an Ontario hospital and certified pursuant to Ontario’s Mental Health Act. At the hospital, his father consented to Chenglei’s treatment with a new medication, valproic acid.
- While in the hospital, Chenglei consistently refused valproic acid. He continued to engage in risky behaviour, including escape attempts. The health care team was concerned about their ability to keep Chenglei safe on the ward.
- A member of the health care team suggested administering valproic acid (in an oral solution) in his juice. The team raised this with Chenglei’s father. Chenglei’s father consented to the delivery of valproic acid in Chenglei’s juice.
• Chenglei’s psychiatrist wrote a new order for valproic acid in liquid form. She consulted with the hospital’s pharmacist about the interaction of the medication with juice.
• After treatment with valproic acid, Chenglei felt better, and he left the hospital.
• Chenglei recently requested his chart from the hospital and discovered that the team had given him valproic acid in his juice. He was upset with his psychiatrist who was involved in the decision to hide medication in his juice. He has since refused to see his psychiatrist and refuses all medication.

Scenario 3

• Andrea is 72 years old. She has a history of dementia-related psychosis for which her physician prescribed a daily dose of quetiapine, in tablet form.
• Andrea was found wandering her neighborhood late at night. She appeared to be in distress and police took her to the hospital. She currently is an involuntary patient at a geriatric psychiatric unit in a general hospital.
• Andrea appears to no longer tolerate quetiapine well. Her health care team decided to switch her medications to olanzapine (tablet).
• She has been found to be incapable of making treatment decisions. Her substitute decision maker is a niece, who lives out of town. Over the phone, her niece consented to the olanzapine.
• At the hospital, Andrea becomes agitated when nurses bring her medication. She spits out the pills. Sometimes, she hides the pills in her cheek. Nurses have discovered a stash of pills in the drawer beside her bed.
• Her health care team is concerned that Andrea is not getting the medication that she needs. They tried to reach Andrea’s niece who did not return their calls.
• The team considered using low-dose haloperidol or loxapine via intra-muscular administration (by injection). The team decided against this because her level of agitation did not warrant this level of intervention and restraint.
• The team administered Andrea’s medication by crushing the tablet and mixing it with applesauce. Olanzapine is not available in a liquid form. The team did not consult with the pharmacist about crushing the medication into food.
• The niece returned the hospital’s call several days later. She was upset that she was not asked before her aunt was medicated in this way. She pointed out that she had only consented to the medication but not to the way that it was administered. She feels that her aunt was tricked into taking the medications.
APPENDIX D: INFORMED CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Full Study Title: The Covert Administration of Psychotropic Medication to Adult Inpatients Determined to be Decisionally-Incapable in Psychiatric Settings
Researcher: C. Tess Sheldon, PhD Student, Dalla Lana School of Public Health, University of Toronto
Members of the PhD thesis Committee:
  Dr. Lorraine Ferris (supervisor), Dalla Lana School of Public Health, University of Toronto
  Dr. Trudo Lemmens, Faculty of Law, Faculty of Medicine, Joint Centre for Bioethics, University of Toronto
  Dr. Elizabeth Peter, Faculty of Nursing, Joint Centre for Bioethics, University of Toronto

INTRODUCTION: INFORMED CONSENT

You are being asked to participate in a research study. The researcher is doing this research as part of her doctoral thesis at the University of Toronto. Her supervisor is Professor Lorraine Ferris.

This form explains the purpose of this research study, provides information about the study interviews, the procedures involved, possible risks and benefits, and the rights of participants.

Please read this form carefully and ask any questions you may have. Make sure all your questions are answered before deciding whether to participate in this research study.

DESCRIPTION OF THE RESEARCH

The topic of the study is medication administration in psychiatric settings. The purpose of the study is to understand the administration of medication to patients or clients of psychiatric settings. In particular, the research looks at the practice of hiding medication in a patient’s food or drink, a practice sometimes known as “the covert administration of medication”.

You are being asked to consider participating in this study because you are a member of a “stakeholder group”, with particular expertise in the area of medication administration to patients and clients in psychiatric settings. A “stakeholder group” refers to a group of people who know a lot about problems and issues that may arise when administering medication to people who might be incapable of making treatment decisions.

Your views about this topic will be sought in a focus group.

WHAT WILL HAPPEN DURING THIS STUDY?
A small number of focus groups will be conducted on the topic of medication administration to adult inpatients of psychiatric settings. The researcher will ask you what you think about hiding medication in the food or drink of patients who are incapable of making treatment decisions.

If you are asked to participate in a focus group interview, it is anticipated that this will take about one or two hours to complete. A focus group is a group interview where members are asked the same questions. It is like a conversation where the researcher is the moderator. About 5 to 8 people will participate in each focus group.

An audio recorder will be used, with your permission, to record the interview, so none of the information you give will be forgotten. Later, the recording will be transcribed, so it can be read.

The focus group will seem like a conversation or discussion. There are no right or wrong answers to any questions you will be asked. The researcher will ask for your views in order to learn how you encounter and respond to issues about the administration of medication to people who have been determined to be incapable of making treatment decisions. During these discussions, the researcher might ask you to explore some of the following questions:

- How you learned about addressing problems related to medication administration?
- What resources and activities might be involved in medication administration during a typical day?
- What documents are involved in guiding or recording medication administration?
- How do you use these documents?
- What barriers or resources do you encounter in addressing medication administration?
- What you would like to change to help you better meet clients’ needs in regards to medication administration?

In the focus group, you will also be asked to talk about three fictional case scenarios.

The collection of information through focus groups or interviews is expected to take about six or nine months to complete.

**WHAT ARE THE RISKS OR HARMS OF PARTICIPATING IN THIS STUDY?**

Although there are no obvious harms associated with taking part in this study, it will involve some of your time and this may inconvenience you.

**WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?**
You will not benefit directly from participating in this study, but you may derive satisfaction from discussing the topic. The result of this research could be important for informing future guidelines and policies in this area.

**CAN PARTICIPATION IN THIS STUDY END EARLY?**

You can choose to end your participation at any time if you decide you do not want to finish the focus group or individual interview. You do not have to answer all of the study questions and can tell the interviewer if there are topics that you do not want to discuss. You can choose not to answer a question even if you have already answered other questions during the interview or focus group.

**PRIVACY AND CONFIDENTIALITY:**

Your responses will be confidential. Only the researcher, Tess Sheldon, and her Supervisor, Professor Lorraine Ferris, will have access to this information. The tapes and transcripts will be kept in a stored locked filing cabinet. The researcher will create new research records that do not contain any identifying information that could link you to your responses. To do this, she will assign a unique identifier to you in the transcripts such that responses cannot be linked back to you. These research records will be used for the analysis and for any reports from the study.

You will be asked to comment on three fictional case scenarios and to refrain from commenting on your own specific experiences. If you or another participant starts to comment on a real-world situation, the researcher will remind you or the other participant to focus on the fictional clinical scenarios.

During the focus group, you will hear other participants’ comments. Please do not reveal to others what individual participants said in the focus group. Nevertheless, it is impossible to guarantee that confidentiality will be maintained with focus group members.

**WHAT ARE THE COSTS OF PARTICIPATING IN THIS STUDY?**

Depending on where you decide to have the interview, the study may cost you nothing, or you may have to pay for travel to a nearby location of your choice. It will involve some of your time.

**ARE STUDY PARTICIPANTS PAID TO PARTICIPATE IN THIS STUDY?**

There will be no payment for participation in this study.

**WHAT ARE THE RIGHTS OF PARTICIPANTS IN A RESEARCH STUDY?**

All participants in a research study have the following rights:
1. You have the right to have this form and all information concerning this study explained to you.

2. Participating in this study is your choice (voluntary). You have the right to refuse to participate or to stop participating in this study at any time without having to provide a reason and without any consequences.

3. You have the right to ask questions about this study and your rights as a research participant and to have them answered to your satisfaction, before you make any decision. You also have the right to ask questions and to receive answers throughout this study. If you have questions about your rights as a research participant or any ethical issues related to this study that you wish to discuss with someone not directly involved with the study, you may call Rachel Zand, Director, Office of Research Ethics, at 416-946-3389.

4. By signing this consent form, you do not give up any of your legal rights.

5. You have the right to receive a copy of this signed and dated informed consent package before participating in this study.

6. Any of your personal information (information that identifies you as an individual) collected or obtained, whether you choose to participate or not, will be kept confidential and protected to the fullest extent of the law. Your name will be removed from transcriptions of the interview as well as names of places and people that you discuss. All personal information collected will be kept in a secure location. The researcher will be obligated to protect your privacy and not disclose your personal information. When the results of this study are reported in journals, dissertations and other scholarly forums, your identity will not be disclosed. The data for this study will be retained for 7 years.

_____________________________________________________


STATEMENT OF INFORMED CONSENT

Full Study Title: The Covert Administration of Psychotropic Medication to Adult Inpatients Determined to be Decisionally-Incapable in Psychiatric Settings

Name of Participant: ________________________________

Participant/Substitute decision-maker

By signing this form, I confirm that:
• This research study has been fully explained to me and all of my questions answered to my satisfaction
• I understand the requirements of participating in this research study
• I have been informed of the risks and benefits, if any, of participating in this research study
• I have been informed of any alternatives to participating in this research study
• I have been informed of the rights of research participants
• I have read each page of this form
• I have agreed to participate in this study or agree to allow the person I am responsible for to participate in this study

__________________________  ____________________________  ________________
Name of participant  Signature  Date
(print)

I also consent to have this interview audiorecorded:

__________________________  ____________________________  ________________
Name of participant  Signature  Date
(print)

Person obtaining consent

By signing this form, I confirm that:
• I have explained this study and its purpose to the participant named above
• I have answered all questions asked by the participant
• I will give a copy of this signed and dated document to the participant

__________________________  ____________________________  ________________
Name of Person obtaining consent  Signature  Date
(print)
1.0 Purpose

Although an incapable client/patient’s substitute decision maker (SDM) consents to the provision of a prescribed medication, the client/patient may not wish to take it when offered. Reaching the planned therapeutic level of a prescribed medication in the client/patient can, therefore, be unsuccessful. A possible option to help reach this treatment goal is covert administration of medication.

Covert administration of medication warrants careful analysis, foresight and adequate safeguards of client/patient rights, recovery and well-being. This policy outlines the limited circumstances in which medication may be administered covertly at CAMH.

Given the relevant clinical, legal and ethical issue surrounding the covert administration of medication, this policy is complemented by CAMH’s Clinical Practice Dilemma: Covert Administration of Medication

2.0 Persons Affected

This policy applies to CAMH clinical staff and physicians working in CAMH inpatient units.

3.0 Policy

Covert administration of medication is a permissible therapeutic option only if and when it has been determined by the relevant inter-professional team and SDM to be justified and preferable to other available therapeutic options.

4.0 Definitions

Covert administration of medication: when a prescribed medication is concealed in food or beverages without the client/patient’s knowledge.

Medication: an approved drug prescribed for treatment of a physical or psychiatric condition.

5.0 Responsibilities

5.1 Most Responsible Physician

• leads the inter-professional teams analysis regarding covert administration of medication.

5.2 Prescriber
• determines the need for use of covert administration of medication in consultation with the inter-professional team, including a pharmacist and a dietician, as required.
• orders and monitors use of the covert administration of medication

5.3 Nursing Staff
• is familiar with all aspects of the covert administration plan, including
  • its rational
  • scope of SDM consent
  • food and/or beverages to which particular medications(s) should and should not be added to and when
  • required monitoring
  • appropriate responses to the expected and unexpected effects of the medication and / or its covert administration.

5.4 Pharmacist
• provides information about the biological-chemical implications of crushing or altering the medication and taking a particular medication with different foods or beverages.

5.5 Dietician
• provides information about any relevant swallowing difficulties experienced by the client/patient
  • assesses dietary implication if the client/patients caloric or nutritional intake decreases

5.6 Unit/Program Management
• annually reviews use of this policy to ensure that is being used appropriately
  • identifies and implements any practice or training improvements, as required.

5.7 Bioethicist
• provides ethics-related analysis and advice regarding the possible use of covert administration of medication

5.8 CAMH Legal Counsel
• provides legal analysis and advice regarding the possible use of covert administration of medication

6.0 Procedures
6.1 Initiating a Covert Administration of medication Treatment Plan
6.1.1 The Most Responsible Physician (if different than the Prescriber) will lead a discussion with the inter-professional team comparing covert medication administration's short term and long term benefits and risks with other therapeutic options. The team will consider the required monitoring, documentation and safeguards necessary to ensure the client/patient's safety, recovery, well-being and therapeutic alliance. This discussion may include input from a pharmacist and a dietician, as required.
6.1.2 The proposed inter-professional treatment plan will be reviewed with the Bioethicist or Legal Services.

6.1.3 If this review affirms that the plan is clinically, legally and ethically justified, the Prescriber will explain the steps taken to develop the plan and propose it to the SMMD for a specific trial period. If the SDM provides consent, covert administration of the particular medication can begin.

6.1.4 The treatment plan and SDM consent will be documented in the client/patient’s health record.

6.2 Implementing and Reviewing a Covert Administration of Medication Treatment Plan

6.2.1 Monitoring, documentation and team collaboration are of added importance in implementing and reviewing a covert administration of medication treatment plan. The client/patient does not know he/she is receiving the medication and so will not self-monitor for its possible effects.

6.2.2 During the trial period, nursing staff will be required by the Prescribers to increase their monitoring and knowledge of the medication’s potential cognitive, psychological, physical and behavioral effects (positive and negative) that could potentially be experienced by the client/patient.

6.2.3 All adverse effects will be documented and addressed in accordance with standard practice and in consultation with the Prescriber.

6.2.4 Appropriate monitoring throughout the trial period includes continued assessment of the client/patient’s capacity to make treatment decisions.

6.3 Ending a Covert Administration of Medication Treatment Plan

6.3.1 The treatment plan will typically end in one of three ways:
   a. the trial period ends prematurely;
   b. the trial period ends. The prescriber will then discuss with the SDM whether covert administration will continue or whether another therapeutic option will be tried; or
   c. at some point during the trial period, the client/patient regains capacity to make his/her own treatment decisions. The prescriber will then explain to the client/patient the reasons supporting the covert medication trial and the various steps taken to safeguard his or her rights, recovery and well-being. The client/patient’s responses will be documented in the health record.

6.3.2 Documentation in the health record may include the end of the trial plan, supporting reasons and any subsequent actions taken by the prescribers and/or inter-professional team members.
Concealed Medication: oral medications, such as crushed tablets or liquids, that are concealed from the patient by mixing with food or drink prior to administration; medications that are crushed and mixed with soft foods or beverages for administration to patients with swallowing difficulties are not concealed medications.

1.1. Concealed Medication

Concealed medication is considered only for patients who are incapable of giving consent.

Informed consent from the substitute decision maker (SDM) for administering concealed medication must be obtained and documented in the chart by the prescriber.
APPENDIX F: TIMELINE - FREEDOM OF INFORMATION REQUESTS

Centre for Addiction and Mental Health (CAMH):

- **June 24, 2009:** Received the response ("it is not our practice to share our policies") to an informal request by email for the CAMH Policy.
- **July 29, 2009:** Made a formal request to the Ministry of Health and Long Term Care (MOHLTC) for CAMH’s Practice Guideline pursuant to the Freedom of Information and Protection of Privacy Act (FIPPA), which did not apply to hospitals at the time.
- **September 8, 2009:** In writing, the MOHLTC advised that they were not in possession of CAMH’s covert medication policy.
- **October 2, 2009:** Appealed the MOHLTC’s decision to Ontario’s Information and Privacy Commission. This appeal was later abandoned.
- **March 9, 2010:** Informally requested, in person, the CAMH Policy and was advised that the policy was under review.
- **March 9, 2011:** Received response, by email, to an informal request for CAMH Practice Guideline: “A CAMH-wide process is being developed for responding to requests relating to the FIPPA legislation when it comes into effect for hospitals and other organizations. So it makes sense for me to wait until this is finished and put into effect here....”
- **January 1, 2012:** FIPPA became applicable to health care facilities.
- **June 1, 2012:** Made an informal request, by email, for CAMH Policy.
- **September 27, 2012:** Received a written response to a formal request for the CAMH Practice Guideline: “...there is no applicable policy at this time that addresses our current practice. However, we are in the process of finalizing such a policy and it is expected to move through the approval process very shortly.”
- **November 28, 2012:** By letter, received CAMH “Covert Administration of Medication” Policy (2008) and was advised that this Policy did not reflect current policy.
- **February 6, 2013:** By letter, received a copy of CAMH “Covert Administration of Medication” Policy (2012).
- **June 10, 2013:** Formally requested, by letter, “background reports, memos, minutes of committee meetings or other related documents that discusses what led to the changes from the old policy to the new CAMH Covert Administration of Medication.”
- **July 3, 2013:** By letter, was advised that CAMH required additional time to respond to the request.
- **July 30, 2013:** By letter, was advised of CAMH’s decision to grant access to agendas and minutes of meetings. Partial access was granted to emails and chart reviews. Access was refused to "briefing notes (draft and finals), iterative versions of the covert medication policy; iterative versions of the Clinical Practice Dilemma and a draft presentation slide deck." The fee for the preparation of the 530 pages was $90.20.
- **September 3, 2013:** Formally applied for a waiver of these fees, setting out that dissemination of the records would support public scrutiny and open debate
about the practice.

- **September 25, 2013:** The application for a fee waiver was denied: "The records at issue pertain to discussions of a policy relating specially to CAMH clients/patients and cannot be said to be directly relevant to the health or safety of the public at large or the dissemination of the records would yield a public benefit." In addition, "[a]ccess to the records for the purpose of your doctoral thesis is more for a private than a public interest."

- **November 6, 2013:** Attended CAMH in person and received 530 pages of documents, paying $90.20 in fees.

**Ontario Shores Centre for Mental Health Sciences:**

- **June 18, 2009:** From the Communications Department, informally requested Ontario Shores’ policy or practice guideline on the covert administration of medication.

- **June 22, 2009:** Received an email response, which included “Guidelines for the Use of Concealed Medication” (2001). The email also indicated that the Policy was under review.

- **March 3, 2011:** Received an email response, which included the revised Policy (2010) by email.

- **September 24, 2012:** Followed up by email, inquiring about the status of the Policy’s review. Was advised that the policy was revised April 12, 2010. W

- **May 14, 2013:** Followed up by email, inquiring about the status of the Policy’s review. Was sent a new policy entitled Medication Administration Policy (2013). Section 1.1 included brief reference to covert medication. Was advised, “…we no longer have a policy strictly on ‘Guidelines for the Use of Concealed Medication.”

- **May 22, 2013:** Made an informal request for the background documents that led to the Policy’s provisions relevant to covert medication. A number of informal follow up requests were made.

- **June 5, 2013:** Was advised by email that these background documents were not available.

- **January 6, 2014:** Made a formal freedom of information request for access to the “background reports, memos, minutes of committee meetings or other related documents that discuss the changes from the old “Guidelines for the Use of Concealed Medication” (WMHC 2001) to the Ontario Shores’ Medication Administration Policy (2013).”

- **March 17, 2014:** Received 14 pages, by letter. Most of the disclosed information included excerpts from committee meetings.