A Comparative Look at the Right to Refuse Treatment for Involuntary Hospitalized Persons with a Mental Illness

Jennifer Fischer
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By JENNIFER FISCHER*

Introduction

The issues surrounding the legal responsibility of caring for and maintaining a person with a mental illness go back almost 2500 years. The Romans asked questions that reverberate today: “What was the legal status of a mentally disabled person during his lucid moments? Was he still under the protection of a guardian? If not, was it necessary to name a new guardian each time the illness returned?”

The answers to these kinds of questions have changed over time in response to changes in culture and advances in technology. With the advent of psychotropic medications in the 1950s, it became easier to treat patients with mental illnesses in the community. These same years saw a push for greater civil rights. Concerns about how patients were treated in mental hospitals, along with the serious side effects that came with the use

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1. MICHAEL PERLIN, 1 MENTAL DISABILITY LAW: CIVIL AND CRIMINAL § 2A-2.1a (2d ed. 1999) [hereinafter PERLIN 1].
2. Id.
3. See generally PERLIN 1, supra note 1, § 2A-2.1 (summarizing the history of caring for mentally disabled persons).
4. MICHAEL PERLIN, 2 MENTAL DISABILITY LAW: CIVIL AND CRIMINAL § 3B-2 (2d ed. 1999) [hereinafter PERLIN 2].

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of the new medications, led advocates for persons with mental illnesses to raise questions about involuntary hospitalization and treatment.\(^5\) Who should be involuntarily hospitalized? Once hospitalized, should these persons have a right to consent or refuse to take medications? There has been considerable debate about these questions in the past few decades, especially in North America and Western Europe. As the importance of mental health and rights of persons with mental disabilities take on greater significance internationally, however, the debate is moving to the rest of the world.

The objective of this paper is to look at the various perspectives in the current debate and at how different countries around the world have answered these questions. Part I of this paper examines the debate over the right to involuntarily hospitalize persons with a mental illness and those persons' right to consent to or refuse treatment\(^6\) once hospitalized. Part II will focus on how this debate has been dealt with on the level of international law. Part III will then take a comparative look at how various countries and regions around the world have come out on the debate and as much as possible examine how the culture and economic realities of the various countries affect these determinations.

**Framing the Debate: Doctors Versus Lawyers**

The advent in the early 1950s of new psychiatric drugs revolutionized the treatment of mental illness.\(^7\) Unfortunately, problems soon arose.\(^8\) Due to a high risk of misdiagnosis, there was a risk of misadministration of the drugs.\(^9\) For those persons correctly diagnosed, there were questions whether the drugs really helped all patients.\(^10\) Possibly more disconcerting was the evidence that staff in state facilities often used drugs for punishment and their own convenience, rather than for treatment.\(^11\) In addition, toxic side effects appeared, including: parkinsonisms (drooling, muscle stiffness, shuffling gate, and tremors), drowsiness, weakness, dizziness, low blood pressure, loss of sexual desire, apathy, and tardive

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5. *Id.*

6. In examining the right to refuse treatment, for purposes of this paper, treatment refers to standard psychiatric or medical treatment and not exceptional or invasive treatment such as electro-shock therapy, sterilization, major medical or surgical procedures, psychosurgery or clinical trials and experimental treatments.

7. *Id.*

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.*
dyskinesia (uncontrollable movements which in the worst cases can lead to death), just to name a few.\textsuperscript{12}

In light of these concerns, the debate over the right to consent to or refuse treatment became a battle between physicians and others concerned about their ability to treat a person who is ill, and patients' rights activists concerned about patients' autonomy and human rights.\textsuperscript{13} These two models are often termed the medical model and the civil rights model.\textsuperscript{14}

A. The Medical Model

The medical model focuses primarily on health as a societal value with a corresponding right to treatment.\textsuperscript{15} Under this model, mental health problems are considered to be potential obstacles to health care, requiring admittance to a hospital for treatment.\textsuperscript{16} Because the rationale of involuntary admission is to give treatment, it alone should justify a forced intervention solely upon a medical decision.\textsuperscript{17} Allowing an involuntarily hospitalized person to refuse treatment is inconsistent with the objective of the hospitalization.\textsuperscript{18} Furthermore, refusing hospitalization or treatment is simply perceived as a symptom of the mental illness.\textsuperscript{19} To allow an involuntarily hospitalized person to refuse a treatment that would return them to their autonomous selves and give them their freedom, in both the psychological and literal sense, is illogical.\textsuperscript{20} A less philosophical concern is that a patient who refuses treatment may have a negative effect on other

\textsuperscript{12} Id. Of these side effects, tardive dyskinesia is the most feared, the most irreversible, and very common. Id. The effects of tardive dyskinesia include uncontrollable movements, especially of the face and mouth. In severe cases, it can impede walking and even breathing and digestion. Id. Not only does tardive dyskinesia create a grotesque appearance, but also can endanger one's health. Id.


\textsuperscript{16} Id.

\textsuperscript{17} Id. at 269-70.

\textsuperscript{18} Id. at 269.

\textsuperscript{19} Id.

patients and staff.\textsuperscript{21}

\textbf{B. The Civil Rights Model}

The civil rights model is founded on values of autonomy and equality with a corresponding right to consent to or refuse treatment.\textsuperscript{22} In other words, having a mental illness, itself, does not make a person incompetent to make decisions about her treatment.\textsuperscript{23} In fact, the MacCarthur Treatment Competence Study has shown that when it comes to the ability to make treatment decisions, there is little difference between most patients hospitalized with a mental illness and people without a mental illness.\textsuperscript{24} Therefore, by making the assumption that a person with a mental illness is incompetent, without more evidence of the incompetence, that person is being treated differently from other people who have an illness that they choose not to treat.\textsuperscript{25} Although many countries treat evidence of dangerousness as that additional evidence, dangerousness alone does not actually prove incompetence.\textsuperscript{26} For example, society also allows someone with lung cancer to smoke, an injured person to refuse a life-saving blood transfusion, and people to go without food, clothing, and shelter either by choice or poverty.\textsuperscript{27} All of these people have engaged in dangerous behavior, but no one is proposing that these same people be forced into a hospital or other detention for treatment.\textsuperscript{28} Such disparate treatment is discriminatory.\textsuperscript{29} Some proponents of the civil rights model, therefore,

\begin{itemize}
\item \textsuperscript{21} Id. at 246-47.
\item \textsuperscript{22} Gendreau, supra note 15, at 269.
\item \textsuperscript{23} Gendreau, supra note 15, at 269.
\item \textsuperscript{25} Gupta, supra note 20, at 256-57.
\item \textsuperscript{26} Gupta, supra note 20, at 258.
\item \textsuperscript{27} SAKS, supra note 13, at 46.
\item \textsuperscript{28} SAKS, supra note 13, at 46.
\item \textsuperscript{29} Gupta, supra note 20, at 258.
\end{itemize}
argue that the issue should not be about dangerousness, but about capacity to make hospitalization and treatment decisions, how likely the person is to suffer deterioration, and how treatable she is.\textsuperscript{30}

As it stands now, there are few governments that require incapacity to be shown in order to involuntarily hospitalize for mental illness.\textsuperscript{31} The hospitalization requirements, therefore, do not ensure that an involuntarily hospitalized person is incapable of making a decision for herself about treatment.\textsuperscript{32} For this reason, under the civil rights model, involuntarily detained persons with a mental illness should be presumed competent until proven otherwise, and given the right to consent to and refuse treatment.\textsuperscript{33} While equality and autonomy are the primary tenets of the civil rights model, other concerns raised include the legitimacy of delegating coercive social control power to psychiatrists and whether forced medication violates the patient’s rights to privacy and freedom from cruel and unusual punishment.\textsuperscript{34}

\textbf{C. Therapeutic Jurisprudence}

An alternative theory that is emerging in the United States is that of therapeutic jurisprudence.\textsuperscript{35} Therapeutic jurisprudence looks at the healing potential of the law.\textsuperscript{36} It recognizes that substantive rules, legal procedures and lawyers’ roles may have therapeutic benefit, contrary to the beliefs of adherents of the medical model, but may also have anti-therapeutic consequences, contrary to the beliefs of adherents of the civil rights model.\textsuperscript{37} It then sets about looking at these effects and attempts to make changes in the law that minimize its anti-therapeutic consequences and maximize its therapeutic consequences.\textsuperscript{38} It is, therefore, a middle ground between blindly insisting on due process rights that may or may not benefit the patient, and the patronizing insistence that a patient with a mental illness does not know what is in her best interest.

\begin{itemize}
\item \textsuperscript{30} Gupta, supra note 20, at 259.
\item \textsuperscript{31} See infra Part III.
\item \textsuperscript{32} Gupta, supra note 20, at 246.
\item \textsuperscript{33} Gupta, supra note 20, at 246.
\item \textsuperscript{34} Gendreau, supra note 15, at 269-70; Gupta, supra note 20, at 246.
\item \textsuperscript{35} See generally DAVID B. WEXLER & BRUCE J. WINICK, LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE (1996); David Wexler, Putting Mental Health into Mental Health Law: Therapeutic Jurisprudence, 16 L. & HUM. BEHAV. 27 (1992).
\item \textsuperscript{36} Bruce J. Winick, Therapeutic Jurisprudence and the Role of Counsel in Litigation, 37 CAL. W. L. REV. 105, 108 (2000).
\item \textsuperscript{37} PERLIN 1, supra note 1, at § 2D-3 (summarizes theory of therapeutic jurisprudence).
\item \textsuperscript{38} Winnick, supra note 36, at 108.
\end{itemize}
One of the most notable cases demonstrating the therapeutic jurisprudence perspective is *Lessard v. Schmidt*, the United States case that established that "a finding of 'dangerousness' to self or others is necessary in order to deprive an individual of his or her freedom" for treatment of a mental illness. In *Lessard*, the court first looked at the roots of the state's involuntary civil commitment power and found that the same fundamental liberties were at stake in both civil commitment and criminal proceedings requiring the same procedural safeguards. In arriving at its conclusions, the court looked at the effect of civil commitment on the person committed, including evidence that lengthy hospitalizations may actually increase the symptoms of mental illness and make transition to society more difficult. The court also considered the substantial loss of civil rights faced by the committed individual. The court gave little credence to the state's contention that notice and an evidentiary hearing in the early stages of confinement may be detrimental to the health of the patient. Rather, the court's response to this contention is most reflective of the court's analysis of therapeutic benefits of due process: "[The] conclusion [that due process is mandated at involuntary civil commitment hearings] is fortified by medical evidence that indicates that patients respond more favorably to treatment when they feel the staff and the system are treating them fairly and as intelligent, aware, human beings." The benefits of using a therapeutic jurisprudence perspective are evident in this decision where "the court was able to fashion a workable standard that took into account the concerns of the state to protect society, provide appropriate care and treatment to its mentally ill citizens, and protect the dignity and civil rights of persons thought to be in need of involuntary civil commitment."

The right to refuse treatment has a strong therapeutic jurisprudence component. Research shows that this right can have therapeutic benefits,
including: providing due process rights for persons with a mental illness; improving checks on doctors and clinical staff; ensuring that “medication and other treatment is not being administered as a means of punishment or convenience; and improving protection from administration of inappropriate medications or medications causing severe side effects, among others.”

Studies have found due process protections provide therapeutic benefits in several ways. First, a formal hearing may force the individual to face reality and provides them with an opportunity to present their own case as well as hear the evidence against them in a formal setting. Due process also provides the appearance of fairness, increasing the individual’s sense of dignity and of being taken seriously. Studies have also shown that medication judicial-administrative proceedings have therapeutic value in that they ensure that patients have the opportunity to thoroughly discuss the medications and their benefits and side effects with their doctors. Misuse of psychotropic medication has long been recognized as a concern to both social scientists and courts, and research

49. Perlin, supra note 41, at 111-16.


52. Perlin, supra note 41, at 114 (citing Note, The Role of Counsel in the Civil Commitment Process: A Theoretical Framework, in Therapeutic Jurisprudence: The Law As a Therapeutic Agent 309, 323 n.83 (David Wexler ed., 1990), Tom R. Tyler, The Psychological Consequences of Judicial Procedures: Implications For Civil Commitment Hearings, 46 SMU L. Rev. 433, 444 (1992) (discussing therapeutic value of judicial civil commitment hearings, and stressing that individuals benefit from hearings in which they can take part, are treated with dignity, and are "fair").


has shown that a right to refuse treatment and the due process proceedings accompanying this right are effective in preventing such misuse. Finally, medication hearings provide a check to ensure that doctors are not prescribing the wrong medications, the wrong dosages, or ignoring patient's concerns about side effects. Such a check is important because even if administered in good faith, psychotropic medication can be anti-therapeutic if there is a misdiagnosis, the patient is not given proper follow-up monitoring, or the side effects outweigh the benefits of the medication.

There are of course arguments that due process is not therapeutic in that it will lead to longer hospital stays for refusers and that patients will become less compliant in their use of medications. The research, however, does not support these conclusions, but rather shows that patients who refuse treatment do not have longer involuntary hospitalizations and that the rate of medication noncompliance did not change once due process proceedings were established.

Unfortunately, although providing a right to refuse treatment and accompanying procedural protections can be therapeutic, the manner in


56. Perlin, supra note 41, at 115 (citing Rennie, 476 F. Supp. at 1305-06).


58. Perlin, supra note 41, at 115 (citing Steven K. Hoge et al., A Prospective, Multicenter Study of Patients' Refusal of Antipsychotic Medication, 47 ARCH. GEN. PSYCHIATRY 949 (1990), Shelly Levin et al., A Controlled Comparison of Involuntarily Hospitalized Medication Refusers and Acceptors, 19 BULL. AM. ACAD. PSYCHIATRY & L. 161, 169 (1991)).

which the judicial system enforces this right is not always therapeutic.\textsuperscript{60} For example, when judges regularly defer to experts and approve involuntary treatment, and the patient's counsel is inept, \textsuperscript{61} the patient may perceive that the right to refuse treatment is only illusory.\textsuperscript{62} When these kinds of situations occur, not only may patients end up with unwanted treatment, but they also do not get the therapeutic benefits of having the right to refuse treatment.\textsuperscript{63}

One factor that may affect the debate in the future is the advances in psychopharmacology over the previous decade.\textsuperscript{64} These new drugs have

\begin{thebibliography}{1}
\bibitem{60} Perlin, \textit{supra} note 41, at 116-17.
\bibitem{62} Perlin, \textit{supra} note 41, at 116-17 (citing Lisa A. Callahan, \textit{Challenging Mental Health Law: Butting Heads With a Billygoat}, 4 \textit{BEHAV. SCI. & L.} 305, 313 (1986) (patient interviews regarding the value of due process procedures used to determine whether a patient could be involuntarily medicated indicated that many were dissatisfied with the process and found it to be a sham)).
\bibitem{63} \textit{Id}.
\bibitem{64} Douglas Mossman, \textit{Unbuckling the "Chemical Straitjacket": The Legal Significance of Recent Advances in the Pharmacological Treatment of Psychosis}, 39 \textit{SAN DIEGO L. REV.} 1033, 1155 (2002).
\end{thebibliography}
greatly reduced side effects and increased benefits. Given that the cases decided up until the early 1990s focused largely on the horrific side-effects of antipsychotic therapies, it remains to be seen whether these advances will lead courts and commentators to re-evaluate the role and value of antipsychotic drugs and the right to refuse treatment.

International Law: The Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care

International law reflects the struggle between the medical model adherents and the civil rights adherents. The primary instrument focused on the rights of persons with a mental illness are the “Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care” (MI Principles) adopted by General Assembly Resolution in 1991. Principle 11 of the MI Principles specifically adopts a right to informed consent to treatment, which implies the right to refuse or stop treatment. The provision of a right of consent reflects deference to the civil rights model.

The Principles provide, however, three specific exceptions for when the requirement of informed consent by the patient may be overridden, reflecting more of the medical model. One exception is for emergency situations: lack of consent may be disregarded if “a qualified mental health practitioner authorized by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or other persons.” When a physician gives emergency, compulsory treatment, however, the “treatment shall not be prolonged beyond the period that is strictly necessary for this purpose.” Consent of the patient is also not necessary where “the patient has a personal representative empowered by law to consent to treatment for the patient.” Finally, the most controversial exception allows treatment to be given involuntarily to an

65. Id. at 1154.
66. Id. at 1155.
68. Id. at Principle 11 (“No treatment shall be given to a patient without his or her informed consent, except as provided for [below].”)
69. Id.
70. Id. at Principle 11(8).
71. Id.
72. Id. at Principle 11(7).
involuntarily hospitalized patient with a mental illness if

(b) an independent authority, having in its possession all relevant information [required to make an informed consent decision according to the Principles], is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment, or, if domestic legislation provides, that having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent; and (c) the independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs.\(^{73}\)

If the patient has an authorized representative who does not provide consent to treatment, however, the representative's refusal may not be overridden under this last exception.\(^{74}\) There is some deference to the civil rights viewpoint in requiring incapacity of the patient and an independent authority to approve the treatment. There is no definition of what constitutes an independent authority, however, so in practice this protection may not amount to much and has been one of the primary criticisms of the MI Principles by civil rights proponents.\(^{75}\)

Stressing the importance of the right to consent, however, the Principles provide that when treatments are authorized without a patient's informed consent, "every effort shall nevertheless be made to inform the patient about the nature of the treatment, and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan."\(^{76}\) Furthermore, the MI Principles provide for a right to appeal any non-consensual treatment.\(^{77}\) The MI Principles also outline certain treatments that may not be given without consent or under greater restrictions: sterilization; major medical or surgical procedures; psychosurgery; and clinical trials and experimental treatments.\(^{78}\)

While many in the mental disability rights community consider the MI Principles to be "core minimum standards under International Human Rights Law," there have been criticisms, particularly regarding the MI

\(^{73}\) Id. at Principle 11(6).
\(^{74}\) Id. at Principle 11(7).
\(^{76}\) MI Principles, supra note 67, at Principle 11(9).
\(^{77}\) Id. at Principle 11(16).
\(^{78}\) Id. at Principle 11(12)-(15).
Principles’ treatment of the right to consent to and refuse treatment. The criticism comes mainly from the civil rights perspective finding that the MI Principles promote a medical approach to mental health problems. In one commentator’s view, the MI Principles essentially create a “dichotomous conception of the protection of the person’s rights and freedoms, in which the right to treatment is set in opposition to other human rights, without sufficient regard to a patient’s own representation of health.” Furthermore, the idea that an independent authority can make the decision for the patient has been criticized by the U.N. Special Rapporteur on disability rights as discriminatory in allowing coercive treatment of a person with a disability, but not other people.

The Right-To-Refuse Treatment Around the World

The debate between the medical model advocates and the civil rights model advocates has primarily affected North America and Western Europe. It is in these countries where the civil rights model has had the most impact. In Asia, developing countries and Eastern Europe, on the other hand, the medical model dominates due to cultural and economic reasons. However, as the rights of persons with a mental illness have become more significant internationally, the debate is moving into these areas. It remains to be seen what effect it will have.

North America

North American mental health legislation and court decisions reflect the tension between the medical and the civil rights models. In both Canada and the United States, provincial or state law controls the decisions to involuntarily detain persons with mental illnesses, although cases interpreting the U.S. Constitution or Canadian Charter of Rights and Freedoms in relation to these laws provide an overarching framework.

79. Rosenthal, supra note 75, at 475.
81. Id.
82. REPORT OF A SEMINAR ON HUMAN RIGHTS AND DISABILITY HELD AT ALMASA CONFERENCE CENTRE, STOCKHOLM, SWEDEN, (Marcia Rioux ed., 2000). While this meeting included representatives of the six major international disability groups, this group of experts should not be confused with the U.N. Panel of Experts authorized by the U.N. General Assembly to advise the Special Rapporteur. The report of the conference does not make specific reference to the resolution adopted by the experts at the meeting.
83. Gupta, supra note 20, at 247.
84. See e.g., Jackson v. Indiana, 406 U.S. 715, 738 (1972) (holding that “at the least, due process requires that the nature and duration of commitment must bear some reasonable
The United States

In the United States, states may detain a person with a mental illness under either their police power or the parens patriae doctrine. Detention under the police power requires both a finding of mental illness and dangerousness to self or others, as established in the Lessard v. Schmidt decision discussed earlier. The basis of the parens patriae doctrine is the state’s interest in caring for an individual who is unable to care for herself. Courts that have upheld the use of the parens patriae doctrine, however, have generally limited the use of the doctrine to cases where the person is, in essence, a passive danger to herself, which includes the incapacity to make a reasonable decision about treatment.

The sources of most legal and social theories driving the debate in the area of a right to refuse treatment are two federal trial court opinions: Rennie v. Klein and Rogers v. Okin. "In Rennie, the district court decided that, in the absence of an emergency, the right-to-refuse treatment is grounded on the emerging constitutional right to privacy." In addition, because of side effects that could include permanent disability, adding forced medication to involuntary confinement constituted a significant enough change to the patient's liberty interest to cause procedural rights to attach. The district court held, however, that there were three factors to relationship to the purpose for which the individual is committed.

85. PERLIN 1, supra note 1, § 2A-4.6.
87. PERLIN 1, supra note 1, § 2A-4.6.
88. PERLIN 1, supra note 1, § 2A-4.6. For example in Colyar v. Third Judicial District Court, 469 F. Supp. 424, 432, 434 (D. Utah 1979), the federal district court held that to sustain a parens patriae commitment, the state must show that: 1) the person is mentally ill; 2) she poses an immediate danger to herself, "which may include the inability to provide the basic necessities of life, such as food, clothing, and shelter;" and 3) because of her illness, "the person is unable to make a rational decision about treatment."
89. PERLIN 2, supra note 4, § 3B-5 (2d ed. 1999).
93. Id. at 1147.
consider in determining if the right could be overridden: 1) whether or not a patient can be confined without endangering other patients and staff, if she is refusing medication that would curb her dangerous tendencies; 2) whether or not the patient is competent to make a decision about drug refusal; and 3) whether or not there is a less restrictive alternative available.\(^9\) In reaching its decision, the district court "made elaborate fact findings as to the conditions of the plaintiff’s hospitalization, the nature of psychotropic drugs, their effects and side effects..., and the plaintiff’s diagnosis and capacity to make decisions with regard to drug use."\(^9\)

Not long after the decision in *Rennie*, the *Rogers v. Okin* court held that hospitals could not forcibly medicate voluntarily or involuntarily detained patients with a mental illness except in cases where there is a compelling state interest such as an emergency "in which a failure to do so would bring about a substantial likelihood of physical harm to the patient or others."\(^6\) To involuntarily medicate absent an emergency would be a violation of the right of privacy under the First Amendment.\(^7\) The court also found that while a person involuntarily detained for mental health reasons did face some "impairment of their relationship to reality," most are competent to make decisions regarding treatment.\(^8\) On the other hand, if a patient had been found incompetent in accordance with state law, a guardian could exercise the consent rights of the patient regarding treatment absent an emergency.\(^9\) While the appellate courts restricted these decisions, they agreed with the district courts in three areas: 1) involuntary hospitalization did not equal incompetence; 2) involuntarily detained patients with a mental illness had a qualified right to refuse psychotropic or antipsychotic drugs; and 3) some kind of procedural mechanism taking into account the issue of side effects and other factors was necessary to ensure effectuation of the right.\(^10\)

Since *Rennie* and *Rogers*, all states but Utah recognize a right to refuse treatment separate from the involuntary hospitalization decision for persons with a mental illness.\(^10\) They also recognize that some judicial procedural protections need to be provided in order to ensure this right with

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94. *Id.* at 1145-46.
95. PERLIN 2, supra note 4, § 3B-5.1a (citing *Rennie*, 462 F. Supp. at 1136-41).
97. *Id.* at 1366-67.
98. *Id.* at 1361.
99. *Id.* at 1364.
100. *Rennie*, 653 F.2d at 843-51; *Rogers*, 634 F.2d at 656-61.
101. PERLIN 2, supra note 4, § 3B-6.
some states providing a greater level of protection than other states. The only state that does not provide for a separation of the involuntary hospitalization and treatment is Utah. In Utah, however, the state can only involuntarily hospitalize a person with a mental illness if the court determines that the person is incompetent to make treatment decisions at the time of the detention order, thus preventing the need to make such a decision at the time of the treatment.

Canada

In Canada, all provinces allow for involuntary hospitalization of persons with a mental illness if they pose a danger or health risk to themselves or others and they refuse to be admitted voluntarily.

102. Id.
104. Id.
Originally, the standard was simply a need for treatment.\textsuperscript{106} The impetus for making the change came about due to two Manitoban court decisions,\textsuperscript{107} \textit{Lussa v. Health Science Centre and Director of Psychiatric Service}\textsuperscript{108} and \textit{Thwaites v. Health Sciences Centre Psychiatric Facility}\textsuperscript{109} These cases established that the criteria for involuntary hospitalization in Manitoba were too vague and subjective and therefore a violation of the Canadian Charter.\textsuperscript{110}

In \textit{Lussa}, the court found that the patient had been detained for twenty-one days without opportunity for review because she was “believed to be mentally disordered and in need of treatment . . . .” The court held that this violated her right to life, liberty and security “except in accordance with the principles of fundamental justice,” her right not to be arbitrarily detained, and her right to be notified of her rights upon detention.\textsuperscript{111} In \textit{Thwaites}, the court was concerned that “in the absence of objective standards, the possibility of compulsory examination and detention hangs over the heads of all persons suffering from a mental disorder, regardless of the nature of the disorder, and the availability and suitability of alternative and less restrictive forms of treatment.”\textsuperscript{112} Thus, dangerousness, as an observable and objectively verifiable standard, became the new criteria for involuntary hospitalization.\textsuperscript{113}

In Canada, there is also a general recognition of a right to refuse treatment.\textsuperscript{114} Replacing the need for treatment standard with the dangerousness standard “implied that hospitalization was not necessarily a vehicle to obtain treatment but was for purposes of restraint or social control.”\textsuperscript{115} As a result, some provinces began allowing for treatment and hospitalization as separate entities.\textsuperscript{116} The first judicial recognition of a competent involuntary patient’s right to refuse treatment came in \textit{Fleming v. Reid}, a 1991 case in Ontario.\textsuperscript{117} In \textit{Reid}, an involuntary psychiatric patient had expressed while he was competent that he did not wish to be

\begin{thebibliography}{99}
\bibitem{106} Gupta, \textit{supra} note 20, at 251.
\bibitem{107} \textit{Id.} at 251-52.
\bibitem{108} \textit{Lussa v. Health Science Centre}, [1983] CarswellMan 403 (unreported).
\bibitem{110} Gupta, \textit{supra} note 20, at 251-52.
\bibitem{111} \textit{Lussa}, [1983] CarswellMan 403.
\bibitem{113} Gupta, \textit{supra} note 20, at 251-52.
\bibitem{114} \textit{Id.} at 252.
\bibitem{115} \textit{Id.}
\bibitem{116} \textit{Id.}
\end{thebibliography}
treated with anti-psychotic medications that he had previously taken for schizophrenia. The Ontario Court of Appeals found that setting aside the patient’s competently made wishes in favor of the physician’s determination of the patient’s present best interest was contrary to his right to life, liberty, and security as guaranteed under section 7 of the Canadian Charter.

Currently, three provinces do not allow a right to refuse treatment once involuntarily hospitalized: Saskatchewan, British Columbia, and Newfoundland. Of these three provinces, however, Saskatchewan requires a finding of incompetence to make treatment decisions due to the mental disability before a person with a mental illness may be involuntarily hospitalized, similar to the legislation found in Utah. In this way, the law ensures that the government may only use hospitalization as a vehicle for treatment, and not to detain for socially undesirable behavior. British Columbia and Newfoundland, on the other hand, recognize a right to refuse treatment, but a physician may override the patient’s decision and treat her anyway in order to ensure that involuntary hospitalization is for treatment only.

In the other seven provinces, a physician evaluates the patient’s capacity to consent to treatment. If the patient is found capable, her decision must be respected. If the patient is found incapable, however, a

118. *Id.*
119. *Id.*
120. BC Mental Health Act, *supra* note 105, at § 22; Newfoundland and Labrador Mental Health Act, *supra* note 105, at § 5(1); Saskatchewan Mental Health Services Act, *supra* note 105, at § 24.1(1).
123. BC Mental Health Act *supra* note 105, at § 31; Newfoundland and Labrador Mental Health Act, *supra* note 105, at § 6(3).
125. Alberta Mental Health Act, *supra* note 105, at § 29; Manitoba Mental Health Act, *supra* note 105, at §§ 26, 29(1)(a); New Brunswick Mental Health Act, *supra* note 105, at § 8.4(1); Northwest Territories Mental Health Act, *supra* note 105, at § 21; Nova Scotia Hospitals Act, *supra* note 105, at §§ 54(1), 56, 57; Ontario Health Care Consent Act, *supra* note 124, at § 10(1); Prince Edward Island Mental Health Act, *supra* note 105, at § 23(1);
substitute decision maker is appointed. The patient can challenge an incapability finding first in a non-judicial review process and later through the courts. In six of the provinces and territories, if a review board finds the patient capable, the physician cannot then override the patient’s wishes. In three other provinces and territories, if a review board finds the patient capable, the physician can still apply to override the capable patient’s decision. Finally, in all provinces, there are provisions for emergency treatment without consent if a patient is mentally incapable and has not expressed prior wishes concerning treatment.

**Western Europe**

Similar to North America, there are currently no European-wide regulations on the involuntary detention of persons with a mental illness, although some recommendations are under consideration by the Council of Europe, and the European Union commissioned a study of the issue.

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Quebec Civil Code, supra note 105, at § 11; Yukon Mental Health Act, supra note 105, at § 21(2).

126. Alberta Mental Health Act, supra note 105, at § 28; Manitoba Mental Health Act, supra note 105, at § 28; New Brunswick Mental Health Act, supra note 105, at § 8.6; Northwest Territories Mental Health Act, supra note 105, at §§ 19.1(3)(c), 19.2, 19.5; Nova Scotia Hospitals Act, supra note 105, at § 54(2); Ontario Health Care Consent Act, supra note 124, at § 20 (1); Prince Edward Island Mental Health Act, supra note 105, at § 23(6); Quebec Civil Code, supra note 105, at §§ 11, 15; Yukon Mental Health Act, supra note 105, at §§ 21(2), 22.

127. Alberta Mental Health Act, supra note 105, at §§ 27(3), (29), (43); Manitoba Mental Health Act, supra note 105, at §§ 50(1)(b), 56(2), 59(1); New Brunswick Mental Health Act, supra note 105, at § 8.4(4); Northwest Territories Mental Health Act, supra note 105, at §§ 19.1(3)(b), 26.1(1), 29; Nova Scotia Hospitals Act, supra note 105, at § 58; Ontario Health Care Consent Act, supra note 124, at § 32(1); Prince Edward Island Mental Health Act, supra note 105, at §§ 23(5), 28(1)(e), 29(12); Quebec Civil Code, supra note 105, at § 16; Yukon Mental Health Act, supra note 105, at §§ 20(3), 31(1), 37(1).

128. Alberta Mental Health Act, supra note 105, at § 29; Manitoba Mental Health Act, supra note 105, at §§ 29(1)(a), 30(1); Northwest Territories Mental Health Act, supra note 105, at §§ 20, 21; Nova Scotia Hospitals Act, supra note 105, at § 58(6); Ontario Health Care Consent Act, supra note 105, at § 10(2); Quebec Civil Code supra note 105, at § 16.

129. New Brunswick Mental Health Act, supra note 105, at §§ 8.4(2), 30.1; Prince Edward Island Mental Health Act, supra note 105, at §§ 24, 28(2)(a); Yukon Mental Health Act, supra note 105, at § 23.

130. Alberta Mental Health Act, supra note 105, at §§ 4, 30; Manitoba Mental Health Act, supra note 105, at § 29(2), (5); New Brunswick Mental Health Act, supra note 105, at § 8.4(3), 8.4(9); Northwest Territories Mental Health Act, supra note 105, at § 20; Nova Scotia Hospitals Act, supra note 104, at § 9(1); Ontario Health Care Consent Act, supra note 124, at §§ 5, 25; Prince Edward Island Mental Health Act, supra note 105, at § 23(11); Quebec Civil Code, supra note 105, at § 13.


132. See infra notes 212-217 and accompanying text.
Thus, each country in Western Europe\(^{134}\) determines its own regulations for the involuntary detention of persons with mental illness, and in some countries, regulation is at the state level.\(^{135}\) Nonetheless, they are all subject to the [European] Convention for the Protection of Human Rights and Fundamental Freedoms\(^{136}\) (European Convention).

The European Court of Human Rights has heard only one case involving the forced medication of an involuntarily detained person with a mental illness.\(^{137}\) The European Court in \textit{Herczegfalvy v. Austria} did not find the forced treatment to be a violation of either his right to be free from inhuman or degrading treatment or his right to privacy under the European Convention and granted tremendous deference to the opinions of medical authorities.\(^{138}\) The opinion, however, recognized the possibility that the outcome might be different if the involuntarily hospitalized person could show that she was capable of making treatment decisions for herself.\(^{139}\) Furthermore, the opinion does not allow courts to escape their duties in protecting the rights of persons with mental disabilities confined in psychiatric hospitals. Courts must ensure that there is, at least, medical necessity for the treatment to ensure that it does not rise to the level of

\(^{133}\) Salize, \textit{supra} note 14.
\(^{134}\) For purposes of this paper, Western European countries include: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, The Netherlands, Portugal, Scotland, Spain, Sweden, and the United Kingdom (England and Wales).
\(^{135}\) Salize, \textit{supra} note 14.
\(^{138}\) \textit{Id.} at §§ 82, 83 & 86.
\(^{139}\) The language of the court's opinion acknowledges an assumption that an involuntarily hospitalized person with a mental illness was not capable of making a decision regarding treatment and grants deference to medical authorities finding that "as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading." \textit{Id.} at § 82. Yet, the court also indicates that the outcome might be different if the person could show that she was capable of making such treatment decisions. First, regarding their finding that there was no violation of the patient's right to be treated humanely, the deference that it expressed to the decisions of medical authorities to decide "on the basis of the recognized rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients" applies specifically to patients "who are entirely incapable of deciding for themselves and for whom they are therefore responsible." \textit{Id.} Furthermore, the court stated that of particular importance in their decision finding no violation of the applicant's privacy was a lack of specific information showing why the hospital authorities were not entitled "to regard the applicant's psychiatric illness as rendering him entirely incapable of taking decisions for himself." \textit{Id.} at § 86.
inhuman or degrading treatment.\textsuperscript{140} In these aspects, the court’s decision seems to somewhat correspond with the idea of therapeutic jurisprudence. There is no indication in the English language literature that the European Court’s decision in \textit{Herczegfalvy} has had an effect on the right to refuse treatment among member countries, however.

The laws of the Western European countries reflect the tension between the medical model and the civil rights model. A study commissioned by the European Union concluded that there was no one influence on member states’ regulations for involuntary hospitalization and treatment.\textsuperscript{141} Instead, legal frameworks or practice are determined by “national legal traditions, structures or standards of quality with regard to the provision of general health care, as well as national approaches or philosophies regarding mental health care.”\textsuperscript{142}

There are essentially five variations on who can be involuntarily hospitalized. Austria,\textsuperscript{143} Belgium,\textsuperscript{144} France,\textsuperscript{145} Germany,\textsuperscript{146} Luxembourg,\textsuperscript{147} and the Netherlands\textsuperscript{148} require both the presence of a mental disorder and

\textsuperscript{140} The court acknowledged “the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals, call[ing] for increased vigilance in reviewing whether the Convention has been complied with.” \textit{Id.} at § 82. Furthermore, the court recognized the necessity of a court satisfying for “itself that the medical necessity has been convincingly shown to exist,” which it found to exist in this case. \textit{Id.}

\textsuperscript{141} Salize, supra note 14, at 155.

\textsuperscript{142} \textit{Id.} at 148.

\textsuperscript{143} Salize, supra note 14, at 46-47 (citing the 1990 Anhalterecht (commitment law) (Austria)).


\textsuperscript{145} Loi No. 90-527 du 27 juin 1990 (JORF du 30 juin 1990), Art. L-333 (France), available at <www.legifrance.gouv.fr/texconsolide/SPEBG.htm>. \textit{See also} Salize, supra note 14, at 75. France’s law is somewhat ambiguous so in practice it may only require a need for treatment, and not dangerousness. (“The person’s state requires immediate care along with constant supervision in a hospital environment.” Loi No. 90-527 du 27 juin 1990.)

\textsuperscript{146} Salize, supra note 14, at 82-86. In Germany, involuntary commitment is regulated by states.


\textsuperscript{148} Salize, supra note 14, at 117 (citing the Psychiatric Hospitals (Compulsory Admissions) Act (17 January 1994) (the Netherlands)).
dangerousness in order for a person to be involuntarily detained. Italy, Spain, and Sweden require a mental disorder and a need for treatment. Denmark, Finland, Greece, Ireland, and Portugal allow the involuntary detention of a person with a mental disorder under either a dangerousness or need for treatment standard. Scotland and England and Wales require both a need for treatment in a hospital and dangerousness. Scotland and Spain, and France additionally require that the person to be hospitalized be incompetent to make decisions regarding her treatment due to the mental illness. The differences among the countries are greater than they appear, however, as the definition of a mental disorder varies greatly among the countries.

Differences in the legislation and practice of Western European countries are even more prominent regarding the right to consent to or refuse treatment. Legislation is not always an accurate indicator of whether

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149. Salize, supra note 14, at 103 (citing Law 833/1978 (Health Reform Text) and Law 180/78 (Basaglia law) (Italy)).
151. Salize, supra note 14, at 134 (citing the Compulsory Psychiatric Care Act (LPT 1991:1128) and the Forensic Psychiatric Care Act (LRV1991:1472) of January 1 1992 (Sweden)).
152. Salize, supra note 14, at 60 (citing the Danish Psychiatric Care Act (1989 revised 1998) (Denmark)).
153. Salize, supra note 14, at 65 (citing the Mental Health Act (1116/1990) passed in 1991 (Finland)).
156. Salize, supra note 14, at 123 (citing Lei de Saúde Mental nº36/98 (The Mental Health Act)). In: Diário da República, I Série A – nº 169; 24/7/98 Imprensa Nacional, Lisbon (Portugal).
157. Salize, supra note 14, at 22.
159. Mental Health Act 1983, § 2 (England and Wales). See also Salize, supra note 14, at 139. Under the 2004 Draft Mental Health Act, if passed, these requirements will essentially change to a requirement of a mental disorder and dangerousness due to a broad definition of treatment. 2004 Draft Mental Health Act § 2 & 19 (England and Wales).
160. Mental Health (Care and Treatment) (Scotland) Act 2003, § 44.
161. L.E.Civ., supra note 149.
162. Loi No. 90-527 du 27 juin 1990 (JORF du 30 juin 1990), Art. L-333 (France). See also Salize, supra note 14, at 75.
163. Salize, supra note 14.
or not such a right exists in practice.\textsuperscript{164} Sweden,\textsuperscript{165} Denmark,\textsuperscript{166} and Luxembourg\textsuperscript{167} all provide for separate modalities of involuntary hospitalization and treatment under the law, but in practice it is not possible to have placement without treatment in these countries.\textsuperscript{168} For example, in Denmark the law separates compulsory hospitalization and compulsory treatment, but consent is not an absolute requirement for either and the requirements for one are the requirements for the other.\textsuperscript{169} Although a psychiatrist must always make efforts to persuade the patient to consent, consent is deemed given if the patient neither verbally nor behaviorally protests.\textsuperscript{170}

Luxembourg and Sweden have a requirement of consent for involuntary treatment, but physicians may override the patient's decision.\textsuperscript{171} In Sweden, this apparent inconsistency might be explained by the purpose of the hospitalization according to the Laws of Compulsory Admission and Involuntary Treatment: "to get the patient into a condition which makes it possible for him/her to participate in voluntary treatment settings."\textsuperscript{172} In essence, this purpose makes it impossible in practice for an involuntary patient to refuse treatment.\textsuperscript{173} The law provides some protection, however, in that decisions to use involuntary treatment must be preceded by less restrictive measures and must be reported to the National Board of Health and Welfare.\textsuperscript{174} In Luxembourg, on the other hand, physicians do not need to justify involuntary treatment and are essentially left alone in their decisions regarding maintenance.\textsuperscript{175}

Ireland is similar to Luxembourg and Sweden in that separate modalities of involuntary hospitalization and treatment exist under the law,
but it is unclear if it is possible in practice to have involuntary hospitalization without treatment, as physicians may override the patient’s decision to withhold consent. 176

Similarly, in the United Kingdom (England and Wales), legislation provides for a distinction between involuntary hospitalization and treatment, 177 but the law allows for compulsory treatment for up to three months if a physician believes it is necessary, after which the approval of a second doctor is required. 178 Unlike Sweden, Denmark, and Luxembourg, however, in practice it is possible to be involuntarily hospitalized without treatment. 179 The United Kingdom has proposed changes to their mental health system, however. Under the 2004 Draft Mental Health Bill, there is no distinction between involuntary hospitalization and treatment although a treatment care plan for each patient must be drawn up within five days of admission and approved by a newly established mental health tribunal. 180 While the patient is to be consulted, there is no provision requiring informed consent of the patient for the care plan to be administered. 181 

Furthermore, under the 2004 Draft Mental Health Bill, it will be possible to involuntarily hospitalize patients over the age of 16 for whom no treatment is available if they pose a threat of harm to others. 182 The Department of Health has explained the reasoning for not allowing persons with capacity to refuse treatment as a matter of public safety and because it would deprive criminal offenders with mental disabilities the opportunity of diversion from the criminal system to the mental health system. 183

Scotland has the most civil rights oriented laws of all of the mental health laws in Western Europe. Passed in March 2003 and entering into effect in April 2005, Scottish law does not allow compulsory treatment simply based on involuntary hospitalization, which requires a showing of incapacity, but rather requires a separate compulsory treatment order approved by a mental health tribunal. 184 A compulsory treatment order

176. Mental Health Act 2001, § 57 (Ireland).
177. Mental Health Act 1983, §§ 2, 3 (England and Wales)
178. Mental Health Act 1983, § 58. See also Salize, supra note 14, at 29, 141, 143.
179. Salize, supra note 14, at 29.
184. Mental Health (Care and Treatment) (Scotland) Act 2003, Part 7; SANDRA MCDougall, SCOTTISH ASSOCIATION FOR MENTAL HEALTH, THE NEW MENTAL HEALTH
may only be issued based on a proposed care plan and after hearing from the patient.\textsuperscript{185} As the Scottish law has only come into practice in April 2005 it is unclear how this act will function in practice.

Behind Scotland in following the civil rights model are Spain and France. In Spain, there is no specific national mental health law.\textsuperscript{186} Therefore, the law regulates the rights of persons with a mental illness together with the rights of other types of patients.\textsuperscript{187} Although the law recognizes a right to refuse treatment, it does not recognize such a right where the person is not capable of making decisions.\textsuperscript{188} Under Spanish law, however, a person must be found incompetent to make decisions in order to be involuntarily hospitalized, and thus there is no right to refuse treatment once a person has already been committed.\textsuperscript{189} France does have specific mental health legislation and does not provide for hospitalization without treatment.\textsuperscript{190} As with Spain, however, a requirement that the person be incapable of providing consent in order to be hospitalized may make the issue of consent moot once the individual is already in the hospital.\textsuperscript{191}

While not reaching the level of Scotland, Spain, and France in regard to involuntary hospitalization, Germany and the Netherlands are both more civil rights oriented than most of the rest of the Western European countries when it comes to compulsory treatment. In Germany, however, because individual states determine the regulations, their laws are somewhat heterogeneous.\textsuperscript{192} Generally, state commitment laws recognize a difference between involuntary hospitalization and treatment, and Federal law requires consent for treatment.\textsuperscript{193} A Constitutional Court of Germany decision confirming a “right to be ill,” exempting society at large from the

\textsuperscript{185} Mental Health (Care and Treatment) (Scotland) Act 2003, § 63,64.
\textsuperscript{186} L.E.Civ., supra note 149. See also Salize, supra note 14, at 131.
\textsuperscript{187} Id.
\textsuperscript{188} Ley 14/1986 del 25 de Abril de “General de Sanidad” Madrid 1986, art. 10 (Spain). See also Salize, supra note 14, at 131.
\textsuperscript{189} L.E.Civ., supra note 150. (“The admission due to a psychological disturbance of a person who is not able to consent, even if he or she is under guardianship, will need judicial authorization . . .”). See also Salize, supra note 14, at 132.
\textsuperscript{190} Loi No. 90-527 du 27 juin 1990 (JORF du 30 juin 1990), Art. L-326, L-333 modifié par Loi n°90-527 du 27 juin 1990 art. 3 (JORF 30 juin 1990) (France). See also Salize, supra note 14, at 75.
\textsuperscript{191} Id.
\textsuperscript{192} Salize, supra note 14, at 82.
\textsuperscript{193} Id. at 83.
responsibility of improving the situation of other citizens by "infringing upon their personal freedoms," supports a right to refuse treatment.\textsuperscript{194} Some states allow for involuntary treatment in cases of emergency with some limiting the emergency to cases that are life threatening, and some to cases where the life of another person is in danger.\textsuperscript{195} Other states require immediate notification of a lawyer or a court when involuntary treatment is given.\textsuperscript{196} There is, however, one state that allows compulsory treatment for any involuntarily hospitalized person despite the fact that its Higher Regional Court has said that treatment may not be forced against the person's will.\textsuperscript{197}

The Netherlands' legislation regulating involuntary hospitalization and treatment, the Psychiatric Hospitals (Admissions) Act, includes both a right to informed consent and a process for determining when a patient is incompetent to make decisions.\textsuperscript{198} Under the Medical Treatment Agreement Act, however, a physician may override the wishes of a temporarily incompetent patient when the physician believes that a failure to intervene will lead to a severe worsening of the patient's medical condition.\textsuperscript{199} Nonetheless, almost all restrictive medical decisions, including finding the person incompetent, may be appealed by the patient or his legal aid through either a complaint procedure or a court.\textsuperscript{200}

Finland,\textsuperscript{201} Belgium\textsuperscript{202} and Portugal\textsuperscript{203} fall on the other end of the spectrum under the medical model. Legislation in these countries does not differentiate between involuntary hospitalization and involuntary treatment, nor are they differentiated in practice.\textsuperscript{204} In Finland, the Mental Health Act does not distinguish between the two because a person can only be admitted to a psychiatric hospital in order to receive treatment.\textsuperscript{205} Although

\begin{itemize}
\item \textsuperscript{194} Id.
\item \textsuperscript{195} Id.
\item \textsuperscript{196} Id. at 83-84.
\item \textsuperscript{197} Id.
\item \textsuperscript{198} Salize, supra note 14, at 117-18 citing the Psychiatric Hospitals (Compulsory Admissions) Act (17 January 1994) (Netherlands).
\item \textsuperscript{199} Salize, supra note 14, at 118.
\item \textsuperscript{200} Id. at 121.
\item \textsuperscript{201} Salize, supra note 14, at 65, 68 citing the Mental Health Act (1116/1990) (passed in 1991) and the Patients' Rights Act (passed in 1993) (Finland).
\item \textsuperscript{202} Loi du 26 juin 1990, Art. 15 (Belgium).
\item \textsuperscript{203} Salize, supra note 14, at 123, 26 citing Lei de Saúde Mental nº36/98 (The Mental Health Act). In: Diário da República, I Série A – nº 169; 24/7/98. Imprensa Nacional, Lisbon (Portugal).
\item \textsuperscript{204} Salize, supra note 14, at 69, 76, 126.
\item \textsuperscript{205} Id. at 69.
\end{itemize}
the Patients' Rights Act guarantees the right to treatment, self-determination, and information, a person detained for a mental illness cannot refuse treatment whether or not she is competent.\textsuperscript{206} Finland's arguments for this position correspond with the arguments of the medical model: the failure to treat is neglecting the needs of a vulnerable person who is unable to ask for help; and that physical freedom is meaningless without freedom from the illness.\textsuperscript{207} The remaining countries of Western Europe fall in the middle of the spectrum between the medical and civil rights models. Legislation in Italy does not provide any distinction between involuntary hospitalization and involuntary treatment.\textsuperscript{208} Involuntary treatments, however, are to be authorized by law and only used as "an extreme solution to be adopted only once all other means of obtaining consent have been attempted," and where there is not time to adequately put in place outpatient treatment.\textsuperscript{209} In practice, however it does not seem to always be the case that it is used as a last resort.\textsuperscript{210} Austrian law requires informed consent for treatment and it is possible to be involuntarily hospitalized without receiving treatment, but consent is not always required in practice.\textsuperscript{211}

It is possible that these disparities between the various Western European countries could narrow in the near future.\textsuperscript{212} The Council of Europe is considering adopting the recommendations of the Working Party on Human Rights in Psychiatry.\textsuperscript{213} The European Council of Ministers appointed the Working Party in 1996 to develop recommendations "to ensure the protection of the human rights and dignity of people with mental disorder[s], especially those placed as involuntary patients in a psychiatric establishment."\textsuperscript{214} The final recommendations include a definition of

\textsuperscript{206} Id. at 72.


\textsuperscript{208} Salize, supra note 14, at 103, 107 citing Law 833/1978 (Health Reform Text) and Law 180/78 (Basaglia law) (Italy).

\textsuperscript{209} Salize, supra note 14, at 104.

\textsuperscript{210} Salize, supra note 14, at 106.

\textsuperscript{211} Salize, supra note 14, at 29, 47 citing the 1990 Anhaltrecht (commitment law) (Austria).

\textsuperscript{212} David Kingdon, Roland Jones, Jouko Lönqvist, Protecting the Human Rights of People With Mental Disorder: New Recommendations Emerging From the Council of Europe, 185 BRIT. J. PSYCHIATRY 277, 277 (2004).

\textsuperscript{213} Id.

\textsuperscript{214} Id.
mental disorder that references international classification systems, and suggest that involuntary hospitalization occur only if there is a mental disorder that "represents a significant risk of serious harm to self or others." The recommendations further stipulate that patients' competency to make decisions regarding their treatment should be assumed even after involuntary hospitalization unless the patient demonstrates incompetence. As the Council of Europe has not yet adopted the recommendations, however, it remains to be seen what kind of impact they will have upon the member countries.

Asia

Laws regulating involuntary hospitalization and treatment of persons with a mental illness in Asian countries are firmly rooted in the medical model and, in fact, Japan was a strong advocate for the medical model during the development of the MI Principles. Their grounding comes from having an "authoritative culture" where "the medical profession has an unquestionable right over the consumer." In Japan, for example, informed consent for cancer treatment has only become a social issue in the last ten years. In addition, Asian culture places a significant emphasis on the community more than on the individual, meaning that the right to privacy is not very significant. One result of this community orientation is that Japanese law allows for hospitalization by the consent of family members.

In China, family is considered to be the most cohesive unit in the society and the tendency is to place family honor, continuation, prosperity, and stability ahead of the individual. Traditionally, the belief is that the presence of a mental illness indicates that a related family member did

215. Id. at 277-78.
216. Id. at 278.
217. Id. at 279.
220. Id.
221. Id.
223. Shinfuku, supra note 219, at 273.
something immoral in this or a past life and thus, family members may be afraid to disclose the illness to prevent bringing shame upon the family.\textsuperscript{225} Combining these factors with the low governmental investment in mental health care, over 90\% of persons with severe mental disabilities live with their families as opposed to only 40\% in the United States.\textsuperscript{226} Of those patients in hospitals, most are in private hospitals paid for by their families, although they may be there involuntarily.\textsuperscript{227} Thus, concerns about a right to refuse treatment when involuntarily hospitalized are issues for very few people with a mental illness. There have been accusations about the use of psychological hospitals to confine dissidents, but to date there is little evidence to substantiate these claims.\textsuperscript{228} The little psychiatric hospitalization that exists, however, has primarily focused on public safety and social control and little on patients’ rights.\textsuperscript{229} Thus, there is no clear policy to prevent abuse of involuntary commitment or a right to refuse treatment.\textsuperscript{230}

\textbf{Developing Countries, Eastern and Central Europe, and Asia: The Impact of Culture and Economics}

Based on limited material written about developing and Eastern and Central European countries, it appears that these countries fall under the medical model, largely due to family and community oriented cultures and a lack of resources for mental health care and protection of individual rights. In many developing countries, local healing systems, which include popular and folk healers, a variety of non-physician personnel, and families, provide the vast majority of care and support for persons with mental illnesses.\textsuperscript{231} In these cases, concerns about involuntary hospitalization and the right to refuse treatment are not raised in the way that proponents of the medical and civil rights models conceive them because they do not exist.\textsuperscript{232} Nonetheless, most, if not all, of these

\begin{footnotesize}
\textsuperscript{225} Id.
\textsuperscript{227} Id. at 87, 90.
\textsuperscript{228} Id. at 92.
\textsuperscript{229} Id.
\textsuperscript{230} Id.
\textsuperscript{231} ROBERT DESJARLAIS, ET AL., \textit{WORLD MENTAL HEALTH: PROBLEMS AND PRIORITIES IN LOW-INCOME COUNTRIES} 54 (1995).
\end{footnotesize}
countries have some type of formal sector.\textsuperscript{233}

In the formal sector, it is questionable whether some of these countries meet the standard of the medical model, as involuntary hospitalization and treatment do not always correlate.\textsuperscript{234} Frequently detention in mental hospitals is not limited to persons with mental illnesses and, due to scarce resources, options for treatment are limited with some facilities simply trying to make do with what they have.\textsuperscript{235} Nonetheless, as mental health takes on greater importance in the international arena, the debate is likely to become more prominent in these countries.\textsuperscript{236} The development of the MI Principles is one example where the debate is extending beyond North America and Western Europe. Watchdog groups such as Mental Disability Rights International (MDRI), who aim to protect the rights of persons with mental disabilities, use these Principles to bring the international debate to the local communities.\textsuperscript{237}

Reliance on the family, which is often necessary when faced with a shortage of mental health resources, is one area where countries are beginning to feel the impact of the debate over the two medical models.\textsuperscript{238} One commentator in Ethiopia expressed the belief that trying to sever the rights of the person with a mental illness from the family would leave the person without any support.\textsuperscript{239} In India, family members are intimately involved in the patient’s mental health care and even reside with the hospitalized patient.\textsuperscript{240} Indian cultural understandings dictate that someone other than the person who is sick must make decisions about the person’s care.\textsuperscript{241} Therefore, once a person is found to be sick, a family member is chosen to be responsible for the person’s care.\textsuperscript{242} Due to a shortage of nurses, the family member fulfills the duties that a nurse ordinarily would: looking after the patient’s hygiene; cooking meals; ensuring the patient doesn’t run away; taking the patient to her therapy sessions; making sure that the patient takes her medications; and keeping the doctor up to date on any changes.\textsuperscript{243} Such intimate family involvement also has the benefits of

\begin{thebibliography}{9}
  \bibitem{233} Desjardais, supra note 231.
  \bibitem{234} See infra pp. 185-87.
  \bibitem{235} Id.
  \bibitem{236} Desjardais, supra note 231, at vii.
  \bibitem{237} See Mental Disability Rights International at <www.MDRI.org>.
  \bibitem{238} Shinfuku, supra note 219, at 273.
  \bibitem{239} Alem, supra note 232, at 95.
  \bibitem{240} Desjardais, supra note 231, at 66.
  \bibitem{241} Id.
  \bibitem{242} Id.
  \bibitem{243} Id.
\end{thebibliography}
providing the patient with social and emotional support and acting as a link between the patient and the outside world.\textsuperscript{244} Furthermore, by keeping the patient tied to her social roots, she often has an easier time adjusting to non-hospital life once the hospital releases her.\textsuperscript{245}

Despite these benefits, there are problems.\textsuperscript{246} For example, in Peru, while the law establishes the right to informed consent,\textsuperscript{247} the consent of family members is sufficient, and, in fact, often the physicians give more credence to what the family says than to the patient.\textsuperscript{248} Unfortunately, this may lead to situations such as that of a sixteen-year old woman who complained about sexual abuse by her grandfather.\textsuperscript{249} Because her family members did not believe her, they authorized electro-convulsive therapy, which the hospital gave her.\textsuperscript{250}

Precisely because of such dangers and because of an emphasis on equality, organizations such as MDRI oppose the practice of the consent of family members taking the place of consent of the patient.\textsuperscript{251} They contend that from a human rights perspective, while it is acceptable for an individual to rely on family members for support in making treatment decisions, it should be the individual's desire that prevails.\textsuperscript{252} The MI Principles reinforce this position in that they are clear that decisions are to be made by the patient herself and no provision is made for decisions by family members unless they are appointed as official guardians.\textsuperscript{253}

\textit{Africa}

Africa has particular difficulty in caring for persons with mental illness and relies extensively on families and social healers, particularly in rural areas.\textsuperscript{254} Some countries have no mental health legislation other than some articles in their criminal and civil codes regarding the treatment of

\begin{footnotes}
\item[244] Id.
\item[245] Id.
\item[246] Id.
\item[247] Article 15 of Peru's general health law No. 26842 provides that consumers of health services have the right "to be informed of all the necessary information to ensure informed consent, before any procedure or treatment, as well as the right to deny such treatment." \textit{See Mental Disability Rights International & Asociación Por Derechos Humanos, Human Rights and Mental Health in Peru} 12 (2004) [hereinafter \textit{Peru Report}].
\item[248] Id. at 13.
\item[249] Id.
\item[250] Id.
\item[251] Id.
\item[252] Id.
\item[253] MI Principles, supra note 67.
\item[254] Alem, supra note 232, at 94.
\end{footnotes}
persons with a mental illness when they have committed crimes, and concerning the protection of their property. Thus, there is a belief that "the right of a psychiatric patient to receive modern treatment to alleviate suffering is not something within the capacity of most African countries."

In Ethiopia, for example, there is no mental health legislation and involuntary hospitalization and treatment only requires informed consent from the escort bringing the individual to the hospital. The escort may be a family member, a friend, a co-worker, or a police officer. One commentator's perspective is that while the procedures in place may be seen as abusive or infringing on basic civil rights, they have protected many people "from vagrancy and the danger of deterioration, which could arise from lack of treatment."

**Latin America**

In a World Health Organization study of Costa Rica, Honduras, Nicaragua, and Panama, researchers found that in practice most compulsory psychiatric hospitalizations had no approval by a judge regardless of the laws of the country and that no patient was entitled to refuse treatment. These findings are consistent with MDRI's reports investigating other countries in Latin America. In Mexico, for example, MDRI found that once a person was placed in a mental health institution, the director of the facility would make all decisions on the patient's behalf as her legal guardian.

In Uruguay, the law limits involuntary detention in a mental health facility to persons with a mental illness, but the law provides no definition of mental illness and detention in such a facility extends to many

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255. Id.
256. Id.
257. Id. at 95.
258. Id.
259. Id. at 96.
262. Law of Assistance to Psychopaths 9.581, article 15, IELSUR (1992) at 17-18 ("Commitment by medical order, meaning involuntary commitment, shall only be for treatment purposes and never be the deprivation of liberty for punitive purposes."). See also MENTAL DISABILITY RIGHTS INTERNATIONAL, *HUMAN RIGHTS AND MENTAL HEALTH URUGUAY* 20 (1995) [hereinafter URUGUAY REPORT].
people without a mental illness.\textsuperscript{263} Furthermore, in the facilities that MDRI inspected, the staff reported that they did not provide information regarding treatment to patients, nor was there a system to establish informed consent.\textsuperscript{264} In fact, at one hospital, the staff believed that informing patients about their treatment would be logistically difficult and would actually worsen the patients' conditions.\textsuperscript{265} At another hospital, staff reported having standing orders to provide psychotropic medication to patients who refuse medication or become aggressive or unruly.\textsuperscript{266} No consent was required, nor was the approval of physicians unless the treatment extended beyond a day or two.\textsuperscript{267} Nonetheless, MDRI did find some psychiatrists who made efforts to inform patients about their treatments in Uruguay.\textsuperscript{268}

\textit{Central and Eastern Europe}

Countries in Central and Eastern Europe face some similar problems to those problems found in developing countries, but all of them have domestic mental health legislation regulating psychiatric detention.\textsuperscript{269} Generally, the requirements for detention are that the person has a mental disability of "such nature or degree that s/he needs to be detained and treated as an inpatient."\textsuperscript{270} For example, in Hungary, requirements for involuntary hospitalization include that the person is diagnosed as mentally ill and constitutes an immediate and serious danger to herself or others or is in urgent need of treatment.\textsuperscript{271} The standard for determining dangerousness or urgent need is, however, open to broad interpretation.\textsuperscript{272}

Unfortunately, emergency procedures provide fewer protections and are used more often than non-emergency procedures, leaving room for

\begin{itemize}
  \item \textsuperscript{263} URUGUAY REPORT, supra note 262, at 20.
  \item \textsuperscript{264} Id. at 41.
  \item \textsuperscript{265} Id.
  \item \textsuperscript{266} Id.
  \item \textsuperscript{267} Id.
  \item \textsuperscript{268} Id.
  \item \textsuperscript{269} Oliver Lewis, \textit{Mental Disability Law in Central and Eastern Europe: Paper, Practice, Promise}, 8 J. MENTAL HEALTH L. 293, 295 (2002).
  \item \textsuperscript{270} Id.
  \item \textsuperscript{272} Health Act of 1972, amendment no. LXXXVII/1994 (Dec. 22, 1994), 35(5) (commitment on the basis of urgent need) (Hungary). \textit{See also} HUNGARY REPORT, supra note 271, at 77 n. 225.
\end{itemize}
As a result, there are concerns about the possibility of involuntary detention and treatment based on the decision of a single doctor, an irritated family member, or police taking people from their homes. In some countries, prosecutors still retain the Stalin-esque power to order detention in a psychiatric institution without prior medical opinion. These policies are beginning to change, however, in the wake of a successful European Court decision against the government of Bulgaria finding such detention arbitrary and a violation of the European Convention.

Although some countries require consent to treatment, hospital staff routinely ignore it, and testimony from patients and former patients indicates that staff rarely provide adequate information about the treatment. In many countries, hospital staff do not view the provision of information as therapeutic. For example, in Latvia, physicians and nurses do not inform patients about their diagnosis and treatment out of fear that it will increase the stigma faced by these patients in society.

Conclusion

The issues over the rights of persons with a mental illness have been around for millennia, but the debate over the right to refuse treatment in an involuntary hospital setting has only arisen in the last few decades with the advent of new psychotropic drugs. Advances in these medications will probably continue to inform the debate for years to come, especially in countries with economies that can afford these new drugs.

The debate between the medical model, emphasizing the right to health and treatment, and the civil rights model, emphasizing the right to equality and autonomy, has primarily influenced practice in North America and Western Europe where a greater emphasis on civil rights is seen. The debate has also spawned a middle ground, that of therapeutic jurisprudence. As mental health takes on greater international importance, the debate is likely to increasingly impact Asia, Africa, Latin America, and Central and Eastern Europe, which are currently more likely to reflect the medical model (to the extent that involuntary hospitalization and a right to refuse
Already these countries have participated in the formulation of the MI Principles, which reflect the debate between the medical and the civil rights perspectives. Furthermore, as watchdog organizations work to hold countries to the MI Principles and other human rights treaty obligations, these organizations bring the debate over the right to refuse treatment to countries that have historically not been involved for cultural or economic reasons.