North Shore
Schizophrenia Society

July 28, 2011

Louise Bradley, President and CEO, and Michael Kirby, Chair
Mental Health Commission of Canada
Suite 800, 10301 Southport Lane SW
Calgary, AB T2W 1S7

Dear Ms. Bradley and Mr. Kirby,

The North Shore Schizophrenia Society is deeply disappointed with the draft Mental Health Strategy for Canada as it not only fails to recognize the realities of severe mental illness but, more dangerously, seems to recommend legislative change that would create potentially life-threatening barriers to treatment for those with severe mental illness.

The North Shore Schizophrenia Society (NSSS) is one of Canada's longest-standing advocacy organizations on major mental illnesses – bipolar disorder, depression, anxiety disorders and borderline personality disorders as well as schizophrenia – with significant experience in mental health law, patient confidentiality, and sharing of information, as well as other legislative matters concerning the treatment of mental illness. NSSS provides families of those with mental illness with personal support and information, crisis support, an education course and a wide range of other programs. We are a front-line organization intimately familiar with the mentally ill and their struggles. To find out more about the organization, our work and our history, please visit our website at www.northshoreschizophrenia.org.

The MHCC draft Mental Health Strategy for Canada, as it stands, does not acknowledge that there is a tremendous difference between "mental health problems" and mental illnesses, with the latter's inherent genetic and neuropsychological characteristics. By referring to "mental health problems and illnesses" throughout the document, without differentiating between the two, severe mental illness, with such symptoms as psychotic episodes, hallucinations and delusions, is marginalized. The most severely ill are being pushed to the back of the line when there are already too few resources dedicated to their needs.

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An effective Mental Health Strategy for Canada needs to clearly differentiate between mental health problems and mental illnesses like bipolar disorder and schizophrenia. Just as it would be unrealistic to expect a strategy for national physical well-being to encompass the treatment needs of those with serious and persistent physical illness, a national strategy dealing with vague, general, mental well-being is going to ignore the clinical needs of those with severe mental illness and downplay the help they need. That is what has happened here.

The draft strategy focuses largely on recovery and the need for an individual's own commitment to defining the means to his or her recovery and recovery goals. What the draft fails to recognize is that treatment for an illness precedes recovery and that people with severe mental illnesses often suffer from anosognosia – an illness-related inability to recognize they are ill. This feature of severe mental illness makes meaningful participation in decision-making and determination of appropriate treatment impossible. If a person believes there is nothing wrong with them and has no appreciation of their own condition, there is little chance – if any – that they will consent to any treatment, leaving them a prisoner of their illness.

While it is encouraging that the draft strategy highlights the need to educate physicians, police, mental health workers and family members regarding the early signs of mental illness in the hope of timely intervention, it needs to go further and ensure that when severe mental illness does develop, access to treatment is not only possible, but is also the first priority, overriding stated objections based on delusions and lack of insight. This means promoting and protecting legislation that allows for involuntary admission to treatment facilities when a person suffering from mental illness is at risk of serious mental or physical deterioration.

Priority 2.3 of the draft strategy points to Canada's ratification of the United Nations Convention on the Rights of Persons with Disabilities (CRPD), highlighting the Convention's focus on legislation that places "a greater focus on protecting human rights, rather than exclusively specifying the conditions under which it is legally permissible to restrict people's freedom against their will." Priority 2.3.1 states as a recommended action the review and reform of "legislation and policies across jurisdictions and sectors, in alignment with the UN Convention on the Rights of Persons with Disabilities."

The suggestion that perfectly good current legislation, like the B.C. *Mental Health Act*, with its provision for appeals, needs "reform" to protect "human rights" simply ignores the reality of serious mental illness and militates against the mentally ill as well. Living with paranoid delusions, auditory hallucinations and major depression is not an act of self-actualization any more than is losing the ability to speak after suffering a stroke. As Herschel Hardin[1] – a life-long civil libertarian – wrote in his 1993 article "*Uncivil Liberties"*, "The opposition to involuntary committal and treatment betrays a profound misunderstanding of the principle of civil liberties. Medication can free victims from their illness – free them from the Bastille of their psychoses – and restore their dignity, their free will and the meaningful exercise of their liberties." You can read the full article at www.northshoreschizophrenia.org/Uncivil_Liberties.htm.

Regarding priority 2.4: reducing the "proportion of people living with mental health problems and illnesses in the criminal justice system," the draft strategy rightly acknowledges that the "best way to avoid involving people living with mental health problems and illnesses with the criminal justice system is to strengthen prevention efforts and secure timely access to services, treatments and supports in the community to all who need them." However, if legislation does not allow for involuntary treatment, the risk is significant that people with severe mental illness will end up in front of a judge before they end up in front of a doctor.

As outlined in the 2008 Vancouver Police Department report *Lost in Transition: How a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources*, police are already being used to intervene when the system fails to treat people with serious mental illnesses, putting them out on the street without medication or supports. The report states that over 30 percent of calls during the sample period involved at least one person with a mental illness – nearly half in some areas of the city. Factors for this alarming rate include "an unwillingness on the part of service providers to fully utilize the provisions of the *Mental Health Act* due to a lack of available resources and/or personal ideology." British Columbia has an excellent *Mental Health Act*, allowing for involuntary admission "to prevent the person's substantial mental or physical deterioration." As noted in the report, however, the lack of capacity in the mental health system leaves many in need of treatment out in the cold.

[1] For purposes of full disclosure, we note that Herschel Hardin is currently NSSS President.

The contradiction between stressing the need for timely access to services and prevention, but not recognizing the legitimate role involuntary admission plays in a person's recovery ensures the intended outcome of Priority 2.4 will not be achieved.

This is not the only instance of a contradiction within the draft strategy that makes a much-needed measure ineffectual at best. Strategic Direction 2 calls for the inclusion of family in treatment: "Wherever possible, families must become partners in the care and treatment of their loved ones, and integrated into decision-making *in a way that respects consent and privacy*. [our italics]" A requirement of consent to share clinical information with involved family members is, however, misplaced, just as it would be misplaced for the sharing of information among other members of the treatment team such as psychiatrists, psychiatric nurses, and case workers.

The B.C. *Freedom of Information and Protection of Privacy Act* (FIPPA) recognizes this. It allows for mental health services to share information with third parties without the person's consent for purposes of continuity of care or protection from risk to health and safety. The emphasis on "in a way that respects consent and privacy" is not in keeping with the law or with the needs of people with severe mental illness, only increasing the likelihood that families of the mentally ill will not be included as members of the treatment team – as called for in best practices – to the detriment of the mentally ill. Many people in the grip of psychosis and paranoia will lash out at those trying to help them – their family members and their mental health service providers. Expecting to gain their consent to share information with those who need it to provide their care is unrealistic. For a full treatment of this question, please see the November 2010 issue of the *NSSS Advocacy Bulletin* on our website.

While the draft strategy appears to provide the appropriate framework for helping Canadians with "mental health problems," it does little to help those afflicted with serious mental illnesses and their families. We fear that implementing the strategy as it stands would only add more barriers to treatment, make recovery more challenging, increase the risk of suicide among the severely ill, and lead to more ill people becoming involved with the criminal justice system as a result of their illnesses.

We cannot view this draft strategy as a positive step toward helping the mentally ill. Furthermore, we call upon the Mental Health Commission of Canada to recognize the gravity of mental illness by addressing it in its own strategy document, and by recommending, in that strategy, that resources be primarily allocated to providing treatment, care, rehabilitation and support for those with a major mental illness, especially the most severely afflicted. By doing so, the Mental Health Commission of Canada can create a valuable tool that helps the mentally ill take the first steps toward recovery, thereby doing the utmost to secure their long-term well-being, dignity, and civil rights.

Respectfully,

Cheryl Olney
Executive Director