

NSSS ADVOCACY BULLETIN

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Mental Health Commission a dysfunctional idea

The Mental Health Commission of Canada and its many tributaries (board, staff, committees, etc.) may not realize how dysfunctional the commission has become, and may never admit to it, but the fallout from the wayward path it has taken is growing.

The things that matter most for the severely ill – early psychosis intervention, sufficient acute care hospital beds, tertiary and refractory care for those hardest hit, and above all the pro-active use of involuntary admission where appropriate – have been either understated or marginalized by the commission.

Instead, the commission seems to have been captured by people who don't understand, or would like to deny, the reality of severe mental illness and the lack of insight that often makes involuntary admission necessary.

Until now, much of this dysfunction in the commission's workings has come in under the public's radar screen. The commission, after all, was created with enormous foofaraw, and it's a "national" commission underwritten by the federal government, with all the corresponding stature.

Its overall budget of approximately \$235 million over nine years, moreover, has given it plenty of heft to market itself.

This immunity from any critical check has now changed with the disclosure of a strategy draft document, *Mental Health Strategy for Canada*, earlier this summer that revealed how badly the commission has been sidetracked.

The draft wasn't supposed to be circulated, except to a selected list of readers for feedback, but it quickly made its way into other hands and generated considerable criticism.

An underlying theme of the document was the suggestion that mental illness arises from "the way in which external environments interact with people" and can be prevented by paying attention to those factors.

The draft document also militated against the use of involuntary admission, notwithstanding the lack of insight of many of those who are ill.

This effective disregard of science-based evidence about mental illness, its biological character, and what is needed clinically to help the mentally ill, amazed outside readers familiar with the subject.

The Globe and Mail weighed in with a column by André Picard.

"There is far too much emphasis on the 'recovery model' – the notion that everyone will get better with [social] support," Picard wrote, "and not enough emphasis on brain science. It's a legitimate approach for those with mild and moderate mental health problems but not those with severe conditions such as schizophrenia.

"In fact, reading the draft strategy, one is left with the unpleasant aftertaste: the distinct feeling that psychiatry and medications have no place in Canada's approach to mental illness."

Picard went on to observe that the report paid far too much attention to the view of self-described "psychiatric survivors" who hide their vehemently anti-treatment views in the promotion of "peer support" and the language of "rights."

"Hope, and false hope," he commented, "cannot be allowed to take the place of care. Where in the strategy, for example, is the call for investment in brain research, psychiatric beds and more addiction treatment facilities?"

NSSS also provided a critical analysis, in a letter to the chair and to the CEO of the commission.

The commission document, aside from its general failure, reveals in its particulars that its authors don't adequately know the field.

In a discussion of "rights" of the mentally ill, for example, the report fails to explore the rationale for involuntary admission where appro-

priate and ignores a key document on the question.

It similarly misses the boat on sharing clinical information with families, excluding such sharing when it's most needed – when the ill person is paranoid and psychotic and won't grant permission – and excluding also citation of legislation like the Freedom of Information and Protection of Privacy Act in B.C., which provides for sharing information in such circumstances.

The authors of the report either hadn't thought things through or were just plain ignorant. It's difficult, in the circumstances, to have confidence in any of their work.

The NSSS letter to the commission, which goes into these matters, is available on our website at www.northshoreschizophrenia.org/media.htm.

The commission, in its policy work, may still think of itself as significant, but those who understand severe mental illness no longer take it seriously – except to regard it as a menace to those who are ill.

It's a great irony: a commission established with considerable hoopla to help the mentally ill should threaten to condemn them to their illness by disregarding or underplaying clinical need and what goes with it.

A misbegotten concept from the beginning

The commission is now doing damage control, with an effusive letter to those who sent in comments assuring them their concerns will be considered and underlining that the document that was issued was only a first draft. NSSS, at least, received such a letter.

What, though, if the very idea of the commission and devising a national strategy was wrong-headed to begin with?

NSSS has been skeptical about the commission from its inception. We feared it would be an unwieldy,

bureaucratic body removed from the day-to-day realities we and our mentally ill relatives face.

For all the commission's efforts at consultation, moreover, we knew that in the end what would count would be the decisions made by those who managed the process. If, moreover, they didn't have a critical grasp of the subject and what's required to get those who are seriously ill back on their feet, they could be misled.

We were nevertheless willing to give the commission a chance.

It didn't take long, however, for our fears to be realized. An original "framework" document in 2009 showed some of the same lack of understanding that came to plague this most recent document.

Subsequently, a vice-chair of the commission came to Vancouver to make a presentation to doctors doing psychiatric training at UBC, to which some family members were also invited. His talk was mostly promotion about the commission and its projects. It took a family member to raise the most pressing issue: how to get people who are deteriorating into hospital for treatment when they lack insight.

The commission's vice-chair waffled on the issue.

NSSS was at that meeting. We left with a sinking feeling.

Then there was the notorious case of the sociologist on the commission's family caregivers committee who denounced psychiatry, thought untreated schizophrenia could be a "gift" connecting people to the spirit world, and more or less blamed families for causing all the problems by not caring for their people.

"What is he doing on a family caregivers committee?" many wondered. The commission's blithe response was that it was important to include all views. "It's like having Ernst Zundel on a committee on the Holocaust," one wag commented.

The failure of the draft strategy document which surfaced this July consequently came as no surprise and confirmed how badly manipulated the commission has become.

One of the telltale signs of a highly questionable approach, as the agency in charge attempts to shape its document, is the use, or rather misuse, of language, to cover its fiddling. The commission's draft strategy is a graphic case in point, resorting to language both

"bureaucratic and wishy-washy," to cite the *Globe and Mail's* description.

Perhaps the most indicative example is the continuing reference in the document to "mental health problems and illnesses," as if vague, undefined "problems" and major biological illnesses could be lumped together. If mental illness is mental illness, why not just say so, and why not, with clarity of language, directly address the problems the seriously ill face?

Any direct coming to grips with the illness, however, and to the necessity of treatment before recovery can properly begin, is avoided.

Eminent researcher Dr. Bill Honer, the Schizophrenia Chair at the University of British Columbia, has aptly noted that, in the whole draft text, the word "schizophrenia" doesn't appear. Nor does the word "psychiatry."

It seems the commission finds even mentioning schizophrenia or bipolar disorder is uncouth – too negative for its upbeat message of recovery. Yet those with schizophrenia and bipolar disorder do improve with treatment, with often inspiring recoveries. Why marginalize them?

The commission appears simply to be afraid to recognize the reality of severe mental illness. Its doctored language, in keeping, lends itself to sloppy, unrealistic thinking and betrays the mentally ill in the process.

Here is another irony stemming from the commission's confused thinking. In marginalizing the seriously ill, in effect putting their illnesses back in the closet where they can't even be named, the commission is stigmatizing the very people for whom they're supposed to be conducting an anti-stigmatization campaign – and receiving many millions of dollars for the purpose.

More than cosmetic change needed

It's all very nice for the commission's CEO to say, with exaggerated earnestness, that critical feedback to the draft document will be considered. Consideration by a dysfunctional agency, unfortunately, is no assurance of anything.

What needs to be first addressed, for example, is the manipulation behind sending the draft document to some people for feedback, but not to others,

especially those involved with the seriously ill. It's not likely, however, the commission will be able to sort this out on its own, because misjudgements like that aren't usually simply administrative errors. They stem, as a rule, from a general attitude in the organization.

The commission, similarly, likes to boast of the number of people who have contacted it and the number of "stakeholders" it has consulted, but that's not reassuring, either. Who decides, from such a mix, what approach to take and what themes to develop?

It comes back to the people who manage the process.

It's not that the commission hasn't done some good things. Some of the specific projects the commission has undertaken, like the At Home/Chez Soi housing project, have been beneficial.

Its downgrading of the seriously ill in its draft strategy document, however, and effective downplaying of their needs, is deeply troubling, whether it comes from a faulty process, built-in bias, or sheer ignorance.

For the commission to properly have done its work, they would have started with the severely ill. They are the ones most affected, who also suffer most from system failure, and who are harmed most by stigma. They deserve priority in the same way that those who are most physically ill are given priority.

What's required for their treatment and recovery, including involuntary admission where appropriate, would then have been fully explored and mandated, and done so in its own terms.

In order for that to happen now, after such a questionable draft document, would mean throwing the draft away and beginning again, with changes in personnel to help make the transition.

Given the way organizations operate, this is something we can't expect.

It means that organizations like NSSS and their members, who speak for the seriously ill, have their work cut out for them, even if they don't have multi-million dollar budgets.

We at least, however, can be counted on.

FEEDBACK WELCOME

We welcome your comments. Please call us at 604-926-0856 or email us at advocacy@northshoreschizophrenia.org.