NSSS BULLETIN

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B.C.'s sensible Mental Health Act not in need of any challenges.
by Guest *on October13th, 2016 at 4:41 PM*

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Lawyers Ruby Dhand and Isabel Grant's argument in "Charter challenge to B.C. Mental Health Act long overdue" (*Vancouver Sun*, September 24, 2016), trying to justify the challenge, is disconnected from what really matters: the ravages of serious mental illness and getting people well.

Serious mental illness, unlike most other illnesses, involves—in many cases, especially with schizophrenia—a lack of insight by the person into their illness, a clinical condition known as anosognosia. The brain, on which insight depends, is affected by the illness itself.

Consequently, for ill people who are deteriorating—or, in their paranoia, becoming dangerous or suicidal but unaware and denying they are ill—society needs to help. It is why we have involuntary admission, following benchmark criteria, and subsequent treatment. Otherwise, we wouldn't need to have a mental health act at all.

On that score—getting people well while safeguarding their rights with an appeal provision—the B.C. Mental Health Act is a leader in Canada. Saskatchewan and Manitoba, by the way, have long had similar involuntary-admission criteria, and Alberta, Nova Scotia, and Newfoundland, in recent years concerned by some of their own experience in the field, have amended their criteria along similar lines.

What exercises Dhand and Grant in particular, though, is that in B.C., treatment follows on the heels of involuntary admission. They indignantly call B.C. an "outlier" for this and allege as fact that B.C. is "the only jurisdiction in Canada that provides compulsory psychiatric treatment" as decided on by physicians. This is both incorrect and misleading. The treatment decision in involuntary-admission cases where the patient is incompetent is also made by physicians in Saskatchewan and Newfoundland. In Quebec, it's done by court order, and in New Brunswick by an administrative tribunal, also without the patient's consent.

Some other provinces, like Alberta and Manitoba, provide for a substitute decision maker, perhaps the closest relative. However, they have to use the same criteria as physicians, and if they reject treatment but the physician nevertheless believes it is in the patient's best interests, the physician can file an application for a treatment order to a review panel. Ultimate authority, then, lies with the review panel.

Note that in all of these variations—decision by physicians, court, tribunal, substitute decision maker, or review panel—the resulting authorized treatment is given without the patient's consent, which is the nature of trying to help someone without insight into their own illness. The advantage of physicians deciding is that it puts the focus clearly on clinical factors and avoids treatment delays, important in cases of psychosis.

Dhand and Grant. instead, seem enamoured by Ontario's legislation, retrograde legislation that can commit someone who is

ill because they're considered dangerous but can in certain circumstances—for example, a previous wish while they were allegedly competent—allow them to refuse treatment. This condemns the ill person to indefinite detention and continuing deterioration, although treatment exists and they've committed no crime. It's a cruel scenario.

The writers even go so far as to cite with approval a controversial Supreme Court of Canada split decision, the Starson case, whereby, under Ontario law, a patient named Starson was found competent to reject treatment although quite ill and delusional, so much so that he couldn't be discharged. The overall result was seven years trapped in detention, with his illness rampaging on, until someone used changed circumstances (delusion-driven starvation) as an excuse to treat him. In another Ontario case, an ill man was kept in seclusion for 404 days because he was out of control but couldn't legally be treated.

In B.C., by contrast, the basic objective of involuntary admission is treatment: to get people well and discharge them. Which is preferable? Why involuntarily admit someone if not to treat them and get them better?

Dhand and Grant also err on other points. They write that "both the common law and the charter are not being adhered to in B.C." This is just wishful opinion. Cases arising from particular Ontario legislation don't apply holus bolus to B.C. On the more general question of involuntary admission and treatment, B.C. does have a landmark charter case, the 1993 McCorkell decision in the Supreme Court of B.C., which found in favour of the Mental Health Act (an earlier version similar to the current one).

The writers' insinuation that the B.C. model produces "dangerous outcomes" is, for its part, wrong-headed rhetoric. The really dangerous outcome is ill people not getting the treatments they need, "madness in the streets", avoidable violence and suicide, the piling up of mentally ill people in jails and prisons, and all the other tragedy and loss that comes from overly restrictive obstacles to treatment.

Dhand and Grant err as well in stating that B.C., alone of all Canadian jurisdictions, has no specific legislative safeguards. Involuntary-admission decisions in B.C. are immediately open to review by a three-member panel and must be heard within 14 days of application, with a decision no later than 48 hours after that. The patient can be represented and the process is highly accessible.

We're lucky in B.C. to have a straightforward, sensible mental-health act that aims at getting people well. Dhand and Grant have grabbed the wrong end of the stick.

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