

Suggested Changes to BC’s Mental Health System regarding Involuntary Admission and Treatment in Non-Criminal Cases

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Table of Contents

1. Overview.....	2
2. Basic Principles / Suggestions	7
3.References.....	9

1. Overview

At some point in their lives, fully one-fifth of BC residents will experience a serious mental disorder.¹ Because there are waiting lists of up to one year to see a psychiatrist outside a hospital, many patients seek help through local hospitals. In BC, only one person – the director or authorized physician – is needed to certify a person for involuntary admission and treatment. This certification can occur without the director or certified physician even personally examining or observing the person: the decision can be based solely on collateral information such as the opinions of others.²

In a recent case that illustrates how the approach taken in BC abrogates fundamental patient rights, an individual with no reported history of mental illness was variously diagnosed as exhibiting symptoms of such conditions as mania and hypomania, the latter a relatively minor mental disorder. This patient was not informed that involuntary admission was being considered, and was assaulted and restrained by security guards when he tried to leave the interview room. He was then confined to a jail-like cell, pinned down on a mattress, had his clothes cut off and was forcibly injected with an anti-psychotic drug. The individual was denied legal counsel for four hours, despite the fact that he had immediately requested counsel when he was initially restrained.³

In BC, neither mentally capable patients (estimated to be a sizeable minority of those involuntarily admitted and treated⁴), previously patient-designated substitute decision makers (SDMs) nor close family members of incapable people have the right to consent to or refuse the involuntary admission or treatment of the patient; it is solely the physician's decision.

Moreover, the admission decision by the authorized physician is based on the doctor's interpretation of the broad and imprecise criteria for involuntary admission* laid out in the BC Mental Health Act (MHA)⁵ and in the legal precedent *McCorkell v. Director of Riverview Hospital*.⁶ These criteria appear to be threefold:

- i) protection from (bodily) harm to self and others,
- ii) prevention of substantial physical and mental deterioration and
- iii) prevention of harm in terms of social, family, work and financial relations.

In order to narrow these overly broad and ambiguous criteria: criterion (i) should refer only to the *likelihood of serious bodily harm*, similar to the criterion found in Ontario's MHA;⁷ criterion (iii) should be eliminated or narrowed to be the *likelihood of serious harm* in terms of social, family, work and financial relations, and involuntary admission should not be considered under criterion (iii) at all unless there is a SDM and/or this is not a first admission and the patient has an advanced directive or Ulysses Agreement that indicates that their denial of the need for admission be ignored.

* BC's MHA Section 22(3)(c)(ii) 'requires, care, supervision and control in or through a designated facility to prevent the person's or patient's substantial mental or physical deterioration or for the protection of the patient or person or the protection of others.' Also harms seemingly are extended to social, family, work and financial relations (see: *McCorkell v. Director of Riverview Hospital*, 1993 CanLII 1200 (BC SC)).

Although the argument is often made that the broad admission criteria are needed to provide effective care to vulnerable people, the imprecision of the current criteria can in fact work against effective protection. This was apparently the case, for example, in the tragic circumstances of MK, a BC man apparently suffering from substantial mental deterioration related to schizophrenia. Despite sixteen attempts by MK's sister to have him admitted, he was refused admission, evidently because the physician reportedly did not see MK as dangerous according to criterion (i) and was unaware or did not understand that substantial mental deterioration was grounds for admission under the other criteria. MK ultimately committed suicide.

In my experience, some physicians may be aware only of the admission criterion of posing physical danger to self and others. For this reason they may not seek admission for those suffering substantial mental or physical deterioration, even though such individuals may subsequently harm or possibly kill themselves (a not-infrequent result of substantial deterioration). Moreover, under BC's Mental Health Act involuntarily admitted patients are not effectively reviewed to determine whether their continued confinement is justified. Increasing the precision of the criteria, as well as ensuring that physicians fully understand them, would serve not only to exclude patients who should not be admitted, but also to protect those who should.

Under the BC MHA, active treatment (such as medication) can begin immediately after admission: a second medical opinion is not required for 48 hours. This second opinion is a re-certification that is often seen as a rubber stamp, and is unlikely to refute the admission and treatment plan of the initial physician. Upon patient request, a Review Panel will assess whether the patient should be discharged or re-certified, but this process is only available after the patient has already been held for approximately one month. While patients may find an advocate to represent them at Review Panel hearings, aid is limited and the number of advocates is insufficient. In practice, many patients must fend for themselves before the three-person panel.

Further, the immunity from liability (provided by the BC Mental Health Act s. 16 to psychiatric unit personnel who acted in "good faith and with reasonable care") seems overly broad and does not reflect previous case law that recognizes the entitlement of capable patients or SDMs to be informed of risks and benefits of proposed treatment and made aware of alternative treatments as well as their entitlement to a standard of care that is contextualized by the physician's specialty.⁸ As a consequence, the patient may lose the right to sue should the treatment prove disastrous and the patient had not been informed of safer alternatives (e.g. in the case of severe leg muscle deterioration due to drug interactions, which caused wheelchair confinement of a 30-year-old woman)[†] and/or if the care of the physician was substandard.

Patients have fewer and weaker rights under BC's MHA than they do under most other MHAs in Canada. BC's legislation utilizes a "physician decides" approach, characterized by broad involuntary admission criteria and no right afforded to capable individuals to refuse involuntary admission and treatment, along with a state-based model

[†] Personal knowledge concerning a patient who received a multitude of different medications which kept on changing along with the various treating psychiatrists.

of authorization for treatment where it is the physician and not a family member or SDM who consents to or refuses treatment for an incapable individual.

In contrast, Ontario's mental health system takes a "patients' rights" approach. Unlike BC, Ontario's scheme is based on two separate statutes: Ontario's Mental Health Act and the Health Care and Consent Act (HCCA).⁹

Ontario's MHA provides:

a) criteria for admission for psychiatric evaluation, including the opportunity for in-depth assessment lasting no more than 72 hours (particularly important for a person not known to the psychiatric facility). This assessment involves care alone and allows time for further consultation with previous mental health professionals (or records); determining whether there is a designated SDM and/or advanced directives; consultation with any SDM and supportive family members, etc. All of these provisions help the physician make a correct diagnosis and assessment of dangerousness.[‡] The above process results in discharge or recommendation for further treatment. This process seems like it would satisfy the frequent complaints by patients that they have received a number of inconsistent diagnoses (which cannot all be correct) along with different medications, without the various doctors being fully aware of the patient's history.

b) allowance for hospitalization for treatment that is either active or consists of care alone, unlike BC's MHA which indicates potential treatment must be "active" (e.g. involving medication) to satisfy admission requirements.¹⁰

In short, both "Admission/Assessment" and "Admission for Treatment" as described in Ontario's MHA require *personal* examination/observation by a physician. The Ontario Act also requires that only a capable person can consent to psychosurgery, including implanted electrodes. This is relevant in light of the recent collaboration between psychiatry and neurosciences that promises to provide advanced technologies such as implanted electrodes which may, for example, offer targeted relief to the clinically depressed who do not respond to medication.

The second statute, Ontario's Health Care and Consent Act (HCCA), provides criteria for consent to treatment for all Ontario citizens with medical issues including those with mental disorders. Such guidelines include the right of capable individuals to reject treatment, and this provision assumes capability unless otherwise assessed. These guidelines also include criteria for capacity assessment, an ongoing process with appeal provisions and the right for capable individuals to make their own decisions; adherence to a person's previous directives concerning SDMs[§] and/or advanced directives (either provided through a representation agreement or otherwise capably expressed); the process to designate an SDM not objected to by the incapable patient, if not previously

[‡] Assessment of dangerousness is often imprecise and time-consuming, necessitating a complete history, including any previous dangerous acts.

[§] SDMs provide another important protection to the individual, for example, a depressed young adult admitted involuntarily after attempting suicide and later discharged. The SDM can keep an "open eye" on the safety of the discharged individual. Also the provision for SDM selection and authority may satisfy, at least in part, the complaint that nobody outside the hospital setting may know of the patient's dilemma.

designated or known; the need to provide the decision-maker with the information required for informed consent, including the least intrusive, effective treatment; ensuring a significant role for supportive family members of an incapable person; provision for a hearing to override advanced directives if not realistic for the present situation; provision to provide a “default” decision maker if the individual has no SDM either previously designated or not objected to by the patient when at the psychiatric unit (usually a family member).

In stark contrast, BC’s Health Care Consent Act¹¹ simply excludes those with mental disorders from the Act. Similarly, people with mental disorders are excluded from BC’s Representation Agreement Act,¹² preventing them from designating SDMs to consent or refuse admission and treatment in a psychiatric unit. Moreover, the above protections, rights and guidelines provided by the Consent Acts and Representation Agreement Act are omitted in BC’s Mental Health Act. *Thus in BC, those with mental disorders are not provided with protection with regard to consent for treatment including the right to designate SDMs, protection given to all others facing proposed medical treatment. This is an unacceptable omission.*

The requirements of the HCCA of Ontario regarding consent and the position of the MHA of Ontario that treatment can be care alone (reflected in the recognition that Admission /Assessment and Admission for Treatment are somewhat distinct processes) as well as the provision for in-depth assessment if necessary suggest recognition that there may be a significant delay between admission and actual treatment. The potential negative effects of this delay are mitigated, however, by the HCCA’s allowance for expedited treatment decisions in emergencies or where the designated SDM cannot be located. These alternative means of giving voice to patient’s intentions are overwritten in the BC legislation. In BC, treatment can begin immediately after admission as it is the physician’s decision and there is no requirement to follow the wishes expressed by any family member, other representative or advanced directives.

The serious problems with the BC MHA’s denial of protections offered by the Health Care Consent Act, BC’s Representation Agreement Act and Ontario’s MHA are further emphasized by Canada’s signing and recent ratification (in April 2010) of the UN Convention of the Rights of Persons with Disabilities.¹³ Article 14 of the Convention says “that the existence of a disability shall in no case justify a deprivation of liberty.” As explained by the UN High Commissioner regarding the CRPD and mental illness “the legal grounds upon which restriction of liberty is determined must be de-linked from the disability and neutrally defined as to apply to all persons on equal basis.”¹⁴

With regard to complaint procedures, the recent Patient Care Quality Review Board Act¹⁵ provides a reasonable procedure for all patients, including those with mental disorders. Unfortunately the complaint provisions of this Act are not well advertised in hospitals, despite assurances I received from the St. Paul’s Hospital Complaint Office that pamphlets and posters were widely available. When I telephoned the clerk at one of St. Paul’s psychiatric units she told me she had never heard of such pamphlets and posters and then refused to talk further and referred me to her supervisor, who never returned my calls. Only after a search of St. Paul’s main floor and elevators did I find one small poster, in a very obscure location. If a major hospital such as St. Paul’s is not effectively advertising the Act, it is unlikely that smaller hospitals are doing so. Furthermore, it appears that the process for patient complaints is so poorly advertised that even

designated advocates for patients at Review Panels may not have heard of the process. One such advocate said that she had never heard of the Act or seen it advertised, although she has been visiting psychiatric units in BC for 20 years.

In addition to the lack of qualitative oversight, there is a dearth of statistical information available on the mental health system. Hospital accreditation (occurring every three years) should include both a quantitative and qualitative review of involuntary admissions, ideally soliciting opinions from involuntary in-patients as well as those who have been discharged. Moreover, statistics should be gathered (and made available to the public) on the number and nature of involuntary admissions, solitary confinements and use of restraints.

There appears to be substantial and widespread dissatisfaction with BC's very conservative (sometimes described as archaic) MHA and its failure to recognize the importance of patient autonomy. This becomes particularly clear when considered alongside Ontario's more rights-protective system with regard to admission and treatment of those with mental disorders. This dissatisfaction may be growing with Canada's recent ratification of the UN Convention of the Rights of Persons with Disabilities.

BC requires changes to its system of mental health delivery to better protect the rights of the estimated 8,000^{**} mentally ill BC residents who each year are involuntarily admitted and treated. The proposals in this paper are based on:

- 1) my knowledge as a psychologist;
- 2) discussion with lawyers, patients who have been involuntarily admitted, parents of individuals with schizophrenia, patient advocacy groups, and psychologists (working inside and/or outside academia), including Dr. John Gray, former director of the BC Schizophrenia Society and author of a book comparing MHA's in Canada;¹⁶
- 3) legal cases related to involuntary admission;
- 4) comparison of BC's MHA with those of other provinces; and
- 5) the excellent discussion paper of Dr. A. Browne "Civil Liberties and the BC Mental Health Act."¹⁷ ††

^{**} Estimate of Dr. John Gray, BC Schizophrenia Society, sent to me by email.

^{††} Dr. Browne used principally a philosophical approach to deal with questions related to involuntary admission criteria, whether or not involuntarily admitted capable patients can refuse treatment and who has the right to authorize treatment. My initial intention was to cover the three major areas of Dr. Browne's paper using an empirical approach as explained above. However, as I became immersed in the project my paper became both more intensive and extensive. I have tried to provide research-based solutions to what I see as major problems with BC's handling of involuntary admissions.

2. Basic Principles / Needed Amendments

1. With the exception of 3(a) below, an individual with a mental disorder should have the same rights and protections as other patients.

2. With regard to consent to treatment, provisions of a) BC's Health Care and Consent Act (without the present exclusion of those with mental disorders) and/or Ontario's Health Care Consent Act (which applies to those with mental disorders), b) BC's Representation Agreement Act (again, without the exclusion of those with mental disorders) and c) something akin to Ontario's MHA should be adopted with the overriding aim being to determine what the person would want if they were deemed capable. These guidelines include:

- the right for capable people to reject treatment and to be the only individuals allowed to consent to psychosurgery, including implanted electrodes;
- certification based on *personal* examination and observation by a physician and not solely on collateral information;
- presumption of capacity unless otherwise assessed;
- criteria for capacity assessment;
- an ongoing process with appeal provisions and the right once capable for the individual to have his/her wishes followed;
- adherence to a person's previous wishes when capable concerning substitute decision makers (SDMs) and /or advanced directives either provided through a representation agreement or otherwise expressed;
- a process to provide an SDM if not previously designated or known;
- the need to provide the decision maker with the information required for informed consent including the least intrusive, effective treatment;
- ensuring a significant role for supportive family members;
- provision of a hearing to override advanced directives if not realistic to the present situation;
- provision for a "default" decision maker if the individual has no SDM.

3. The attending physician should not be able to override the decision to reject active treatment but may override the rejection of admission (a) by an SDM or advanced directives if the incapable person is likely to cause serious bodily harm to self or others and (b) by a capable person likely to cause *imminent* serious bodily harm to others. The latter criterion appears to be similar to that for all citizens.

4. Points 1 to 3 (above) should refer to two somewhat distinct processes, not only (a)

consent for treatment but also (b) where at all feasible, consent for admission for care alone and/or in-depth assessment to determine a potential treatment plan.

5. “Treatment” should be understood as potentially care alone and need not be “active” such as medication.

6. There should be an emphasis on in-depth assessment and recognition of the often necessary delay between assessment and active treatment to ensure correct diagnosis and determination of the patient’s wishes.

7. BC’s three major admission criteria should be narrowed or more precisely defined into three distinct categories. Harm should be *likely* and *serious* and if the harm involves social harm (e.g. family, financial and work relations), there should be extra protection to avoid abuse of the criterion – for example, requirement for a previously designated SDM or advanced directives.

8. There must be an avenue for competent advocacy for decisions related to admission, treatment, and hearings.

9. The MHA’s exemption from liability clauses (section 16), should not shield psychiatric unit personnel from charges of medical malpractice due to lack of informed consent or substandard treatment.

10. To ensure continuous improvement there must be effective oversight, well-advertised and speedy complaint procedures, and relevant data collection and statistical analysis (e.g. number and nature of involuntary admissions, solitary confinements and use of restraints).

3. References

- ¹ “Mental illnesses in Canada: an overview” A Report on Mental Illnesses in Canada, Public Health Agency of Canada, 2002.
- ² *Mullins v. Levy*, 2002 BCSC 1366; 2005, BCSC 1217; 2009, BCCA 6.
- ³ *Ibid.*
- ⁴ Okai D et al. “Mental capacity in psychiatric patients” *The British Journal of Psychiatry* (2007) 191 (4): 291-297.
- ⁵ BC Mental Health Act (RSBC, 1996) amended 1999, 2005.
- ⁶ *McCorkell v. Director of Riverview Hospital*, 1993 Canlii 1200 (BCSC).
- ⁷ Ontario Mental Health Act R.S.O. 1990, Chapter M.7.
- ⁸ See *Brock v. Anderson*, 2003, BCSC 1359; *Semeniuk v. Cox*, 2000, ABQB 18; *Seny v. Crooks*, 1998, ABCA 316; Picard E and Robertson G. *Legal Liability of Doctors and Hospitals in Canada*, 4th Edition, 2007, p. 249.
- ⁹ Health Care Consent Act, 1996, S.O. 1996.
- ¹⁰ BC Mental Health Act (RSBC, 1996) amended 1999, 2005. 4, S.22(3)(c)(i)
- ¹¹ Health Care (Consent) and Care Facility (Admission) Act (RSBC 1996) Chapter 181.
- ¹² Representation Agreement Act (RSBC, 1996) Chapter 405.
- ¹³ UN Convention of the Rights of Persons with Disabilities, December, 2006.
- ¹⁴ Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary- General, 2009.
- ¹⁵ Patient Care Quality Review Board Act of BC, Bill 41, 2008
- ¹⁶ Gray J et al. *Canadian Mental Health Law and Policy*, 2nd Edition, 2008.
- ¹⁷ Browne A. *Civil Liberties and the BC Mental Health Act*, Discussion Paper for the BC Civil Liberties Association, 2008.