

**B.C. *MENTAL HEALTH ACT***  
**SEPARATING**  
**FACT FROM FICTION**

North Shore Schizophrenia Society  
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# OVERVIEW

- Resources for using the *Mental Health Act (MHA)*
- Need for and purpose of the MHA
- Involuntary Admission Criteria
- Involuntary Admission Procedures
- Authorizing (consenting) to Treatment
- Discharge from involuntary in-patient care
- Extended leave
- Rights and Review Panels

# *MENTAL HEALTH ACT*

## RESOURCES

1. Guide to the *Mental Health Act*, 2005 Edition, British Columbia Ministry of Health (google)
2. Local psychiatric unit/ mental health centre staff
3. General practitioner
4. Schizophrenia society
5. (general reference) *Canadian Mental Health Law and Policy, 2<sup>nd</sup> Edition*. JE Gray, MA Shone, PF Liddle, LexisNexis, 2008.

# WHY A MENTAL HEALTH ACT?

- No Cardiac Health Act
- Schizophrenia etc are brain illnesses that:
- Impair insight because of delusions, thought disorder, so people refuse treatment
- Untreated mental illnesses can cause serious harm to the person and to other people
- Legal basis: protection of society (*police powers*) and *parens patraie*

*MYTH:*

INVOLUNTARY ADMISSION IS  
NOT NEEDED, ONLY MORE  
USER-FRIENDLY SERVICES

■ REALITY:

- *Despite the best medication and services in the World, involuntary access is essential because some people with these brain illnesses, especially when psychotic, do not believe they have a treatable illness and therefore refuse voluntary admission and treatment.*

# INVOLUNTARY ADMISSION CRITERIA

- 1. Not suitable as a voluntary patient AND
- 2. Definition of mental disorder (“disorder of the mind that requires treatment and seriously impairs the person’s ability (a) to react appropriately to the person’s environment, or (b) to associate with others”)
- 3. Definition of harm. Needs admission “for the protection of the patient...or other” OR
  - 3a. “to prevent the patient’s substantial mental or physical deterioration” AND
- 4. “requires [psychiatric] treatment”

# *MYTH*

Only people with a mental illness  
who are a “danger” to themselves  
or others can be committed  
(the law and the *Charter* say that)

## ■ *REALITY*

- The person must need “protection” from harms. Harms can be physical or “that relate to the social, family, vocational or financial life of a patient” (judge in McCorkell, page 9 Guide)
- Now even broader; likelihood of substantial mental or physical deterioration qualifies
- The McCorkell judge said the *Charter* does not require physical danger

# *MYTH*

If the ill person won't see a doctor voluntarily there is nothing you can do.

## ■ *REALITY*

- The Police are appropriate in an emergency and may help in non-emergency (persuasion or MHA powers) OR
- Provincial Court Judge or if not available Justice of the Peace

## *MYTH*

# IF THE PATIENT OR RELATIVE REFUSES CONSENT, TREATMENT CANNOT BE GIVEN

## *REALITY*

- In BC all involuntary patients are treated (they can consent if capable. If not capable the unit director consents in their best interests)
- Incapability and treatment cannot be reviewed by the Review Board
- Ontario: the BC Myth is True e.g. Sevels

# TREATMENT REFUSAL

- Mr Sevels 404 days in seclusion because Ont forbade treatment (previously expressed competent wish).
- Judge “ it surely cannot be the intended result of the application of the Charter of Rights and Freedoms that persons who are entrapped in the cage of their mental illness and who are medically diagnosed as chronically unable by the nature of their disease to give or refuse informed consent... be for prolonged periods caged and warehoused in mental health facilities whereas the key to their necessary and involuntary seclusion is available with relatively little likelihood of substantial risk.” (Sevels)

## *MYTH*

An advance directive (*Representation Agreement Act*) allows an involuntary patient to dictate treatment

## *REALITY*

- In BC the *Representation Agreement Act* excludes *Mental Health Act* involuntary patients including those on extended leave. Applies to physical problems of involuntary patients
- Ontario: the BC Myth is true

# PROBLEMS WITH TREATMENT DELAY AND REFUSAL

- Prolonged patient suffering
- Poorer prognosis (duration of psychosis)
- Increased seclusion, restraints, assaults
- Illogical “If treatment cannot be provided by the facility to which the patient is committed, there is no jurisdiction for continuing the committal” Sask Law Reform Commission.
- Patient refuser trap (Starson)
- Ethical dilemmas for physicians and nurses.

## *MYTH*

Only patients with many admissions qualify for extended leave (compulsory community treatment)

## *REALITY*

- Only one admission is required
- s. 37 “if the director considers that leave would benefit a patient detained in a designated facility, the director may release the patient from the designated facility providing appropriate support exists in the community to meet the conditions of the leave”

## *MYTH*

Discharge criteria, used by the dr and Review Panel, are the same as admission criteria

## *REALITY*

- Although the criteria are the same the considerations are different
- review panel must consider "...patient's history of mental disorder" and "an assessment of whether there is a significant risk that the patient, if discharged, will as a result of the mental disorder fail to follow the treatment plan ...to minimize the possibility that the patient will again be detained.." s.25

## *MYTH*

# Families cannot provide information to the Review Panel

## *REALITY*

- A Review Panel is a lawyer, physician and another person, appointed by the Minister of Health to review requests for discharge against medical advice.
- Although usually the patient does, families can request a review
- Families can provide evidence, by phone or in person, with permission of the Chair

# FAMILIES AND LEGISLATION

- Facilitate access to treatment (e.g. get to MD, judge; provide information, assist in hospitalization)
- Receive notices of admission, discharge and rights. May exercise rights on person's behalf
- Participate in treatment planning
- Evidence at Review Boards
- Discharge and post discharge involvement (e.g. leave)
- Advocate for law and systems reform