

BRITISH COLUMBIA SCHIZOPHRENIA SOCIETY POSITION PAPER ON THE CHARTER CHALLENGE TO TREATMENT FOR INVOLUNTARY PATIENTS UNDER THE BC MENTAL HEALTH ACT

INTRODUCTION

The challenge under the Charter of Rights and Freedoms (Charter Challenge) seeks to change BC laws so that involuntarily detained psychiatric patients can “refuse or revoke consent to psychiatric treatment...;”

British Columbia Schizophrenia Society’s (BCSS) position on this challenge is that it misunderstands current BC laws and the laws are in accord with the Charter. Furthermore, if the challenge is successful, it will cause strife between patients who do not want treatment and their family substitute decision maker (SDM) who consents to unwanted treatment. It will also lead to dire consequences for untreated involuntary patients, families, physicians, nurses and the service system.

A. The Charter Challenge: a wrong interpretation of the BC Mental Health Act

The challenge incorrectly asserts that the BC Mental Health Act (MHA) is “...legislation, which deprives all involuntary patients...of the right to give, refuse or revoke consent to psychiatric treatment, regardless of those patients’ actual capacity to do so.”

In fact, the MHA requires physicians to assess the capacity to consent to proposed treatment for every involuntary patient before they can be treated, using the BC Mental Health Act Form 5, “Consent for Treatment (involuntary patient).” The physician must explain to each involuntary (certified) patient “the nature of the condition, options for treatment, the reasons for and likely benefits and risks of the treatment.” If the patient is found to be capable, they can sign consent for their own treatment. If the patient is found to be incapable by the physician “The physician explains, orally or in writing, to the director or designate, the nature of the patient’s condition and the reasons for and likely benefits and risks of the treatment(s).” (BC Ministry of Health, Guide to the Mental Health Act, page 85, 2005) and the director consents, or not, to the proposed treatment.

The challenge also wrongly claims that BC is the only province where an official, rather than a substitute decision maker (SDM) such as a family member, consents to treatment. In fact, Saskatchewan, New Brunswick, Quebec, and Newfoundland and Labrador do not allow an SDM to consent but require a physician or official to authorize the treatment. These provinces do so because they view treatment as being the purpose of involuntary admission and a necessary requirement for release.

B. Charter issues

BCSS strongly believes that the current BC MHA and related legislation are in accord with the Charter. The challenger wrongly claims that having an SDM consent to treatment is the only method allowed by the Charter and therefore BC law is contrary to the Charter. However, three other provinces use an official like BC It is the understanding of BCSS that the Charter does not require that all provincial laws be the same, they can be quite different, but they must conform with the Charter.

The purpose of the legislation is very important in Charter decisions. The challenger wants involuntary patients who have been committed because they need treatment, need protection for themselves or

others and cannot be admitted as a voluntary patient, to be able to refuse the treatment necessary for their release. The McCorkell BC Supreme Court decision, however, made it clear that the purpose of involuntary admission in BC is for treatment. (It is not in Ontario where people can be hospitalized for well over a year or kept in seclusion for over 404 days because they could not be treated. see Solomon reference). Treatment refusal for involuntary patients, advocated by the challenger, is not consistent with the purpose of the BC MHA.

Similarly, the Saskatchewan Law Reform Commission wrote “Civil commitment exists to provide treatment for seriously disturbed patients. If treatment cannot be provided by the facility to which the patient has been committed, there is no jurisdiction for continuing the committal. Logically therefore, authority to direct hospitalization without consent of the patient must entail authority of some form of treatment without consent” (see Gray et al., p. 248).

The challenger says that the equality section the Charter (section 15), means that involuntary patient must be treated the same as voluntary patients thus be able to refuse treatment. Since voluntary patients can refuse admission, to be consistent, the challenger should argue that seriously ill dangerous person must be able to refuse involuntary admission. This illustrates why involuntary psychiatric patients are not “equal” to voluntary patients: they cannot refuse admission and cannot discharge themselves when they want. Discharge is only possible after successful treatment. The MHA does not therefore violate section 15 of the Charter.

Because of the well documented increase in length of detention, increased seclusion and restraint associated with treatment refusal, BCSS argues that the Charter rights of liberty, autonomy and freedom of thought will be violated by the challenger’s proposed changes.

The MHA contains a number of protective mechanisms including clear committal criteria which require that the person must need psychiatric treatment, two independent physicians for committal, second opinions on the appropriateness of the treatment, notification to patients and families, two professionals involved in treatment consent (treating physician and director) and review panels. BCSS is of the opinion that these rights protective mechanisms along with the treatment purpose of the MHA are sufficient to obviate concerns about any deprivation of liberty (section 7).

C. Family Substitute Decision Makers

The challenge would have decisions to treat or not made by an SDM, usually a family member. Most family members want to be closely involved with the development of the treatment plan for their involuntarily admitted family member. However, many do not want to be the person who actually consents to the treatment which the involuntary patient may be actively resisting. Oftentimes the relationship with the patient is easily disturbed. As one person who meets weekly with her son said “If I had to consent to treatment he did not want, even though it was necessary, all hell would break loose and my relationship with my son probably destroyed.” She is very comfortable with being able to inform her son that it is the director who consents not her.

A number of family members also expressed concern that they are not experts in treatment and do not know one medication from another. They therefore prefer the current system where professionals make the ultimate decision. That is the system used in a number of provinces.

Some foreign jurisdictions forbid family members from making treatment decisions that can restrict liberty rights. It is argued that family members may be in a conflict of interest and are not sufficiently at arm's length to make objective decisions.

Another issue is delays when the person is acutely ill and the SDM not easily accessible. Under the current system treatment can happen quickly when the patient is in the greatest distress.

The BCSS position is that the current system for treatment consent is in accord with the Charter and preferable for many families of seriously ill people, and protects the right to treatment for an individual who is unable to make the treatment decision themselves.

D. The Negative Consequences of Refusing Treatment for Involuntary Patients, Families, Staff, and Society

1. The Negative Consequences for Involuntary Patients When Treatment is Refused

- Continued suffering due to non-treatment of delusions, hallucinations and other serious symptoms of psychosis.
- Longer detention in hospital or community.
- More seclusion and restraints to manage un-medicated psychotic behaviour.
- Poorer prognosis. Research indicates that prompt treatment leads to reduced negative cognitive impacts, fewer re-occurring episodes of psychosis and less trauma for individuals with psychosis.
- Denial of liberty and autonomy rights because patients cannot be released from hospital until they are well and this is unlikely without treatment.

2. The Negative Consequences for Other Patients, Staff and Service System When Treatment is Refused

- Increase in fellow patients being assaulted.
- Increase of assaults on nurses and other staff raising Worksafe concerns.
- Ethical dilemmas for physicians and nurses whose professional ethics are to heal.
- Transforms psychiatrists and nurses from health care providers to jailers, since they will only be able to detain a patient, but not treat them.
- Increased cost to taxpayers as the seclusion and closer monitoring of untreated patients requires more staff resources.
- Increased wait times for a limited number of beds that will be caused by those who cannot be discharged because of treatment refusal.
- Increased premature discharge of involuntary patients given the pressures around bed usage and the refusal to accept treatment.
- Higher incidence of relapse, victimization by criminals and increased intervention by police and criminal justice.

3. The Negative Consequences for Families When Treatment is Refused

- Families are increasingly burdened with the responsibility of caring for individuals with serious mental illness. They find themselves having to serve as advocate, caregiver, and emotional

support. This Charter challenge asks them to also become a mental health expert, someone who understands all the relevant research and treatments for their loved ones.

- If treatment is refused, families will experience distress as they watch their family member suffer for long periods.
- Treatment can be delayed while the physician finds and convinces the family SDM.
- Strife may occur between family SDM and the patient who does not want the treatment.
- Because treatment refusal will lead to longer hospital stays, the person's family will be helpless in getting their family member back to the community, to their job, and family role. This can be very disruptive to family life.

CONCLUSION

BCSS, which is an organization founded by families of people with schizophrenia, the most debilitating of the mental illnesses, strongly refutes the claims made in this Charter Challenge. From the experience of our members, and families in other provinces, we are convinced that this challenge will not advance the treatment or the rights of people whose brain illnesses so severe that they cannot accept treatment voluntarily and can only access treatment through involuntary services.

REFERENCES

[McCorkell v. Director of Riverview Hospital, 1993 CanLII 1200 \(BC SC\)](#)

[John E. Gray et al., eds., "Psychiatric Treatment Authorization and Refusal" in *Canadian Mental Health Law and Policy 2nd ed.*, \(Markham: LexisNexis, 2008\)](#)

[Robert Solomon, Richard O'Reilly, John Gray & Martina Nikolic, "Treatment Delayed – Liberty Denied" *Canadian Bar Review* \(2009\) 87, 679-719](#)