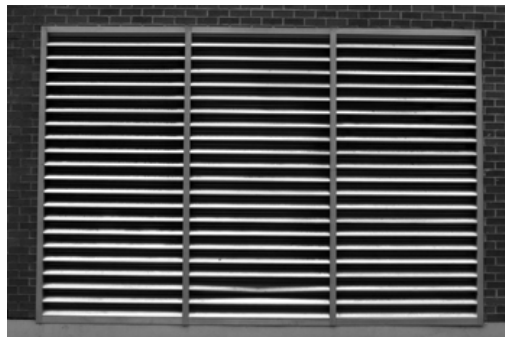




# Operating in Darkness

## BC's *Mental Health Act* Detention System



Community Legal  
Assistance Society

November 2017

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### Operating in Darkness: BC's Mental Health Act Detention System

By Laura Johnston

Community Law Program, Community Legal Assistance Society

November 2017 (revised)

This project was generously funded by  
the Law Foundation of British Columbia



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This report describes the law generally as of November 2017. It does not provide legal advice on individual legal problems, and should not be relied upon as legal advice.

Thank you to the legal advocates and lawyers who generously contributed the time to share their experiences and expertise. The views expressed in this report are those of the Community Legal Assistance Society and do not necessarily reflect the views of the funder or the research participants.

This research project was reviewed and approved by the Community Research Ethics Board of the Community Research Ethics Office.



Graphic design by Nadene Rehnby, Hands On Publications

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*The photo series for this report conveys feelings and impressions about the BC mental health system, but is not intended to depict any facilities in BC. See "About the photographer" on page 183.*



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# Executive Summary

**IN BC, PEOPLE WHO HAVE, OR ARE PERCEIVED TO HAVE,** mental disabilities, can be detained in facilities for their benefit or the benefit of others. Detention is an extraordinary and intrusive exercise of state power in any context. But for individuals in mental health detention, the loss of liberty is only the beginning of rights deprivations. Once detained in the BC mental health system, the detaining facility controls virtually every aspect of your life and your body. You can be denied access to a phone or the internet. You can be denied visitors or the right to go outside for fresh air. Your clothing can be removed by force from your body and you can be denied access to your own clothes. You can be forcibly administered psychiatric treatment, including injections and Electroconvulsive Therapy. You can be placed in mechanical restraints that tie you to your bed. You can be put in seclusion.

In a free and democratic society, such extraordinary power must be carefully administered with fair procedures and safeguards to ensure appropriate checks and balances. In BC, the *Mental Health Act*<sup>1</sup> and the *Mental Health Regulation*<sup>2</sup> govern the administrative system of mental health detention and involuntary psychiatric treatment. The mental health detention system is administered by health authorities, who are in turn accountable to government ministries, such as the Ministry of Health. *Mental Health Act* detainees can challenge their detention in court and through review panels constituted by an administrative tribunal, the Mental Health Review Board.

This research set out to explore two questions. First, are the substantive and procedural rights of detainees in BC which are set out in the *Mental Health Act*, the *Mental Health Regulation*, and the policies of the Mental Health Review Board and Ministry of Health being meaningfully observed and fulfilled? Second, if these rights are being observed and fulfilled, has that been sufficient to uphold the administrative fairness and constitutional rights of detainees in BC? If not, what changes to law, regulation, and policy should be made?

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1 R.S.B.C. 1996, c. 288, online: <[bclaws.ca/civix/document/id/complete/statreg/96288\\_01](http://bclaws.ca/civix/document/id/complete/statreg/96288_01)> [*Mental Health Act*].

2 B.C.Reg.233/99,online:<[bclaws.ca/civix/document/id/complete/statreg/233\\_99](http://bclaws.ca/civix/document/id/complete/statreg/233_99)> [*Mental Health Regulation*].





# PLEASE KEEP DOOR CLOSED

The goal of this research project was to investigate and make public some of the most common and troubling components of the administrative system for mental health detention and involuntary psychiatric treatment in BC.

What became clear over the course of conducting this research was how little attention and analysis BC has given our mental health detention system. While other Canadian jurisdictions have been conducting systemic reviews to evaluate whether their legal framework was functioning effectively to further legislative goals and fulfilling the rights guaranteed by the *Canadian Charter of Rights and Freedoms*<sup>3</sup> and the United Nations Convention on the Rights of Persons with Disabilities,<sup>4</sup> BC has neglected this critical engagement. While comparable mental health tribunals in other Canadian jurisdictions produce annual reports detailing performance measures, member training efforts, statistical trends in applications, and outcomes of appeals from the tribunal to the court, the BC Mental Health Review Board publishes no annual report. The legal representatives who participated in this research repeatedly described our mental health detention system as opaque, unclear, and obscure — a system in which people are tucked out of sight with no monitoring, oversight, or accountability.

We have allowed our mental health system to stagnate and operate in darkness. As a result, BC is considered the most regressive jurisdiction in Canada for mental health detention and involuntary psychiatric treatment. Many individuals diagnosed with mental disorders leave BC to live in other jurisdictions simply to avoid our mental health system. BC has fallen far behind other Canadian jurisdictions on numerous measures. The *BC Mental Health Act* and the *Mental Health Regulation* are outdated, deeply flawed, and inadequate to fulfill the rights guaranteed by the *Charter* and the UN CRPD.

The goal of this research project was to investigate and make public some of the most common and troubling components of the administrative system for mental health detention and involuntary psychiatric treatment in BC. The scope of this project was necessarily limited. This research was only made possible through the funding of a non-governmental organization, the Law Foundation of BC, and the generous contributions of time from non-profit sector staff and volunteers who participated in

<sup>3</sup> Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, c. 11 [*Charter*].

<sup>4</sup> G.A. Res. 61/106, U.N. Doc. A/RES/61/106 (Dec. 13, 2006), online: <[un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html](http://un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html)> [UN CRPD].

**We have allowed our mental health system to stagnate and operate in darkness. As a result, BC is considered the most regressive jurisdiction in Canada for mental health detention and involuntary psychiatric treatment.**

the research. This report does not, and could not, detail all of the problems with the administrative system for mental health detention and involuntary psychiatric treatment in BC.

It is clear from the findings of this report that significantly more investigation and action is necessary. The *Mental Health Act* detention system does not just need a few amendments or tweaks, it needs to be overhauled. Given the range of actors responsible for creating and administering this system – legislators, police officers, health care professionals, and administrative tribunal members to name a few – and the complexity of the relevant statutes, regulations, policies, and practices, a comprehensive and wide-ranging review is necessary. The BC Government should establish an independent law reform commission to critically analyse the current mental health detention system and point us towards a transparent system that fulfills the principles of dignity, equality, and self-determination.

Much more work needs to be done. To use the words of one of the research participants, a long-time mental health advocate, my hope is that this report will begin this process by turning on a light.

*The Mental Health Act detention system does not just need a few amendments or tweaks, it needs to be overhauled.*



# Introduction

## RESEARCH CONTEXT

Judicial oversight is a healthy and transparent part of any administrative system that provides a safeguard against unfair or deeply flawed decisions.

**IN THE COMMUNITY LAW PROGRAM** at the Community Legal Assistance Society, we review the decisions of many different decision makers operating in multiple administrative systems that impact individuals living in poverty. Individuals seek our legal advice and representation when they want to challenge the decision of an administrative decision maker, such as a tribunal. When a tribunal has not followed the principles of procedural fairness in reaching a decision or the decision is unreasonable, we represent clients in court proceedings to overturn the decision. This judicial oversight is a healthy and transparent part of any administrative system that provides a safeguard against unfair or deeply flawed decisions. Every year, the Community Law Program provides legal representation in court to clients challenging decisions from many different BC tribunals: the Residential Tenancy Branch, the Human Rights Tribunal, the Workers' Compensation Appeal Tribunal, and the Employment and Assistance Appeal Tribunal, to name a few.

However, the Community Law Program has never represented a client in court challenging a decision of the Mental Health Review Board, despite concerted efforts. The complete lack of judicial oversight of this tribunal was an indication to us of two things. First, that the administrative system for mental health detention was operating without sufficient oversight and accountability. Second, that we needed another method to investigate and evaluate how that system was fulfilling the substantive and procedural rights of *Mental Health Act* detainees. This research project is our attempt to address both issues. While detainees face multiple barriers in initiating oversight and accountability mechanisms—an issue that will be discussed further in section 7 | **Oversight and Accountability**—individuals who provide legal representation to detainees challenging their detention have a wealth of insight and experience on this administrative system.

This research documented the experience and expertise of individuals who provide legal representation to detainees challenging their detention pursuant to the *Mental Health Act* at review panels of the Mental Health Review Board. These



The complete lack of judicial oversight of this tribunal was an indication to us of two things. First, that the administrative system for mental health detention was operating without sufficient oversight and accountability. Second, that we needed another method to investigate and evaluate how that system was fulfilling the substantive and procedural rights of *Mental Health Act* detainees. This research project is our attempt to address both issues.

individuals have both the direct experience of working with people in mental health detention and the legal training necessary to be familiar with *Charter* rights and fair procedures in administrative systems. The role of a legal advocate or lawyer is to listen to the concerns and perspectives of detainees and ensure that their voice is heard by detaining facilities and decision makers in legal proceedings.

Throughout the course of this project, 21 interviews were conducted with lawyers and legal advocates who had provided legal representation to clients challenging their *Mental Health Act* detention at review panels. For simplicity, this report will refer to all the research participants who represented clients at review panels as “representatives”. There were three categories of representatives who volunteered for the research:

- 1) Nine representatives were lawyers and legal advocates who were employed by the Mental Health Law Program, which is funded by the Legal Services Society (legal aid);
- 2) Seven representatives were lawyers or law students who had volunteered through Access Pro-Bono’s Mental Health Program; and
- 3) Five representatives were lawyers in the private sector who were hired privately by detainees or who were paid through legal aid tariffs.

Cumulatively, the representatives interviewed for this research had first-hand experience representing thousands of detainees in psychiatric facilities and in community based settings across the province. The representatives had a diverse range of experiences. Some had over 25 years of experience representing hundreds of detained clients every year. Others had represented detainees at a few review panels as a volunteer during law school. This is a result of BC’s turbulent history of legal aid funding for *Mental Health Act* detainees at review panels. While representation at review panels should generally be provided by legal representatives who work in clinical and tariff funded legal aid structures, volunteers in the non-profit sector have attempted to cover legal aid shortfalls in BC in recent years, as described in the following section.

Cumulatively, the representatives interviewed for this research had first-hand experience representing thousands of detainees in psychiatric facilities and in community based settings across the province.

## HISTORY OF LEGAL REPRESENTATION AT REVIEW PANELS

Every individual who faces a deprivation of her liberty is constitutionally entitled to state-funded legal representation if she cannot afford to hire a lawyer. However, *Mental Health Act* detainees have not been able to consistently access legal representation at review panels for several years. In BC, the Legal Services Society is responsible for administering legal aid. The Legal Services Society is funded by the BC Government, with additional support provided through various grants. Since approximately 1992, the Legal Services Society has contracted with the Mental Health Law Program to provide legal representation to individuals detained under the *Mental Health Act* who are financially eligible for legal aid. With rising detention numbers throughout the early 2000s, the Mental Health Law Program sometimes had to refuse representation to detainees when there was no advocate or lawyer available to cover the hearing.

In 2009 the Mental Health Law Program reported to the Legal Services Society that the increasing number of detentions combined with the funding freeze to the program resulted in 191 requests for representation from detainees who were entitled to legal aid being refused in the 2008/2009 fiscal year. Despite this, legal aid funding did not increase to cover the shortfall in legal representation at review panels. As the number of individuals detained in BC continued to increase and the funding to the Mental Health Law Program remained frozen, the number of detainees denied representation rose every year for several years. By the 2015/2016 fiscal year, detainees who were entitled to legal aid were refused representation 639 times.

When detained individuals were denied legal representation at review panels by the Mental Health Law Program, they were faced with a terrible choice: adjourning their review panel to a later date until legal representation was available and therefore prolonging their detention, or proceeding to a review panel unrepresented. The crisis in legal aid for *Mental Health Act* detainees was repeatedly and resoundingly criticized for years. In the 2011 report *Foundation for Change: Report of the Public Commission on Legal Aid in British Columbia*, Leonard T. Doust, Q.C. condemned the shortfall in legal aid funding for representation at review panels as a “profound violation of the rights of one of the most vulnerable segments of our community”, citing a submission that detainees “are at a significant and inhumane disadvantage when trying to present their cases for de-certification versus powerful, educated and skilled professionals, usually their own psychiatrists and other health care professionals.”<sup>5</sup>

In 2014, Access Pro-Bono established the Mental Health Program to try to mitigate the significant shortfall in representation at review panels. Access Pro-Bono’s Mental Health Program maintained a roster list of volunteers who provided legal representation at no charge to individuals who were denied representation by the legal aid funded Mental Health Law Program. Access Pro-Bono’s Mental Health Program provided assistance to over 400 *Mental Health Act* detainees and provided legal representation at 210 review panel hearings between 2014 and 2016. Despite these efforts, many detainees did not have representation for review panels as the number of individuals denied legal aid continued to rise.

In 2016, the BC Public Interest Advocacy Centre, acting in conjunction with pro-bono private bar lawyers, filed a constitutional challenge on behalf of a woman who had been denied legal representation by the Mental Health Law Program in *Z.B. v British Columbia (Attorney General)*.<sup>6</sup> The BC Attorney General settled the constitutional challenge by increasing the legal aid funding to the Mental Health Law Program to

5 Public Commission on Legal Aid, *Foundation for Change: Report of the Public Commission on Legal Aid in British Columbia* (Vancouver) (Leonard T. Doust, Q.C.), online: <[http://www.publiccommission.org/media/pdf/pcla\\_report\\_03\\_08\\_11.pdf](http://www.publiccommission.org/media/pdf/pcla_report_03_08_11.pdf)> at 36.

6 Notice of Civil Claim, Vancouver Registry, No. S-167325 (B.C.S.C.).

provide legal representation to all detainees eligible for legal aid. As a result, Access Pro-Bono's Mental Health Program has transitioned to cover another gap in legal aid — the provision of legal advice on *Mental Health Act* detention — which will be discussed in more detail in section 3 | [Access to Information and Legal Advice](#).

While the significant shortfall in representation has been addressed as a result of the settlement of the Z.B. law suit, the numerous years of legal aid deficiencies are relevant context in considering the issues raised in this report. Many of the research findings identify shocking patterns of substantive and procedural fairness rights violations in the administrative system for mental health detention. Access to lawyers and legal advocates is a fundamental component in safeguarding the rights of individuals with less power, who are vulnerable to having their rights ignored or violated. It is instructive to consider how the lack of access to legal representation could have contributed to widespread rights violations for *Mental Health Act* detainees documented in this report. Adequate legal aid coverage is a critical first step in ensuring that there are legal advocates and lawyers in place to advocate for reform to our mental health detention system.

There are many different actors in the administrative system for mental health detention beyond those who represent detainees. It was outside the scope of this research to investigate the perspectives of other individuals involved in the mental health detention system, such as health care providers, police officers, tribunal members, and, critically, detainees themselves. Where relevant, the report references other research that has documented these perspectives, but this is an area in need of further research.

## A NOTE ON LANGUAGE

This report is published at a time when many changes are being made to the governing structures and the actors responsible for administering the system of mental health detention and involuntary psychiatric treatment in BC. Over the course of this research project, the tribunal responsible for review panels pursuant to the *Mental Health Act*, the Mental Health Review Board, has been transferred from the Ministry of Health to the Ministry of Attorney General. Recommendations for changes to the tribunal's policies and practices will be made to the [Mental Health Review Board](#), but these changes will undoubtedly also require involvement from the responsible ministry.

For many years in BC, the Ministry of Health has been responsible for the health authorities that provide health care services, including detention and involuntary psychiatric treatment pursuant to the *Mental Health Act*. There are five regional health authorities that govern, plan, and deliver health care services within their geographic areas: Fraser Health, Interior Health, Island Health, Northern Health, and Vancouver Coastal Health. The First Nations Health Authority plans, designs, manages, and funds the delivery of First Nations health programs and services in BC. Finally, the Provincial Health Services Authority oversees the co-ordination and delivery of provincial programs and specialized health care services. For example, the Provincial Health Services Authority is responsible for BC Children's Hospital, where children may be detained under the *Mental Health Act*.

However, while this report was in its final stages, a new BC government was formed, which established a new ministry—the Ministry of Mental Health and Addictions. At the time this report is published, it is still unclear what the respective mandates and roles of the Ministry of Health and the new Ministry of Mental Health and Addictions will be. As a result, recommendations for change that require ministerial leadership and monitoring as well as the involvement of the health authorities will be made to the **Ministries of Health and Mental Health and Addictions in conjunction with the health authorities**.

Where this report recommends a review or amendment to legislation or regulation, it will be directed to the **BC Government**. While the Ministry of Attorney General is responsible for providing legal advice to the BC Government, the Minister responsible for a particular subject area is generally in a leadership position in reviewing legislation and proposing amendments to the legislature. The relevant ministry is also responsible for reviewing and changing regulations pursuant to the legislation. At this time, it is unclear which ministry or ministries will be involved in the review and amendments to the *Mental Health Act* and its regulations, but the BC Government is ultimately responsible for its legislation and for regulations that govern the administrative system for mental health detention.

Individuals who come into contact with the mental health system identify themselves in a variety of ways. Some identify as having a mental illness, while others do not agree with the diagnoses given to them by health care professionals. Some see themselves as patients, while others view their atypical mental function as a social disability and do not agree with the disease-based model that uses the term “patients”. Some identify as “consumers” of mental health services, while others see themselves as “survivors” of detention and forced psychiatric treatment. This report will use the statutory language of the *Mental Health Act* by referring to an individual who has been involuntarily detained as a “patient” or “detainee”.

Finally, the language used to describe psychiatric treatment is as contentious as the topic itself. While many people use the term “medications” to describe a type of psychiatric treatment, others find that term misleading or offensive, because many psychiatric treatments do not have a curative or therapeutic effect, but rather have a sedative effect that alters behaviour. For example, many point out that the term “anti-psychotics” is a misnomer because these pharmaceutical agents do not combat psychosis like anti-biotics combat bacteria and instead call these pharmaceutical agents “neuroleptics”, as they depress neurological function.<sup>7</sup> On the other hand, the term “drugs” has a negative connotation that can be offensive to individuals who have experienced improvements to their mental health symptoms with psychiatric treatment.

This report takes no position on the benefits, efficacies, or safety of psychiatric treatments. Experiences of psychiatric treatments vary widely. Some individuals experience great benefits with psychiatric treatments that have improved their quality of life. Others have experienced no benefit and instead, only negative side effects. Decisions about whether and how to engage with psychiatric treatments are highly individual and this report takes no position on health care decisions that individuals make. As a result, this report will prioritize neutral language over plain language and will use the term “psychotropic pharmaceutical agent”—psychotropic meaning relating to or affecting a person’s mental state and pharmaceutical agent meaning a manufactured compound that takes an active role or produces a specified effect.

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7 See for instance, Joanna Moncrieff, “Magic Bullets for Mental Disorders: The Emergence of the Concept of an ‘Antipsychotic’ Drug” (2013) 22:1 J. Hist. Neurosci. 30, online: <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4118918/>>.



# Report Overview

**THIS REPORT HAS BEEN STRUCTURED** to mirror the order in which an individual experiences the administrative system for mental health detention. This system is first engaged by the decision of a physician acting as an administrative decision maker on behalf of the state to detain an individual. Section 1 | **Detention Decisions** considers the application of criteria for detention and detention renewal, the qualifications and procedures for physicians making detention and renewal decisions, and the discharge of detainees who no longer meet detention criteria. The *BC Mental Health Act* criteria are very broad and there are few procedural safeguards in place for detention decisions. While in many areas of law the level of state intervention on an individual's liberty and security has generally been decreasing over time and procedural safeguards that ensure fairness when those interventions occur have, correspondingly, been increasing, involuntary mental health detention has followed the opposite trajectory. The last significant amendments to the *BC Mental Health Act* passed in 1998 expanded the criteria for detention and reduced the procedural checks and balances involved in detention decisions.

Given the broad criteria and minimal procedural fairness involved in detention decisions, it is unsurprising that data reveals that the number of involuntary detentions has been rising in BC. While data tracking mechanisms are incomplete, available data indicates that involuntary admissions have risen from at least 11,937 to 20,008 per year over the last ten years. What is surprising, however, is that while involuntary admissions have been steadily increasing over the last decade, the number of voluntary admissions has remained virtually unchanged. Voluntary admissions have gone from 17,659 to 17,060 per year over the same ten year period.

Given that the number of all admissions should have increased with population growth, the complete stagnation of voluntary admissions in the face of increasing involuntary admissions indicates that our mental health system now predominantly interacts with people with mental health problems in an adversarial way, by removing their rights to make decisions, rather than in a voluntary way that promotes autonomy and collaboration in the recovery process.

In making detention decisions, physicians must examine individuals to assess whether they meet the legal criteria for detention pursuant to the *Mental Health Act* and document

This report has been structured to mirror the order in which an individual experiences the administrative system for mental health detention.



the reasons for their decision in regulatory certificates. Detainees have a constitutionally guaranteed right to be promptly provided with the reasons for their detention, however, representatives reported that detaining facilities frequently violate this right by failing to provide detainees with their certificates. Representatives also reported that the reasons for detention that physicians provided on certificates were often illegible and wholly inadequate to explain the application of the legal criteria. Although the *Mental Health Act* requires that a physician conduct an examination to make detention decisions, there is longstanding uncertainty about whether a physician can “examine” an individual without conducting an in-person assessment. Representatives reported that they had represented detainees who had been detained by a physician who had not conducted an in-person examination, but instead had relied on a conversation with another physician or a review of medical records. These and other practices detailed below raise concerns that individuals are not receiving the independent and procedurally fair decision making process they are entitled to while being detained.

During the initial involuntary admission procedure, and at any point in time throughout the detention period, detainees can be subject to physical, mechanical, environmental, and chemical restraints and placed in seclusion (solitary confinement in a small, locked room). Section 2 | [Restraints and Seclusion](#) considers the use of restraints and seclusion and the practices surrounding detainees’ clothes and clothing removal. While Canada has been engaged in a vigorous debate about the appropriate limits on the use of solitary confinement with inmates in correctional settings, particularly inmates who may have mental health problems, we have completely overlooked its use in psychiatric detention settings.<sup>8</sup> The BC *Mental Health Act* actively authorizes the staff at detaining facilities to subject every patient to “direction and discipline” during detention.<sup>9</sup>

There are no criteria in the BC *Mental Health Act* and its regulations that define, govern, or establish oversight of restraint and seclusion use against detainees. Representatives reported that it is impossible to get a clear picture of the full extent of restraint and seclusion use in detaining facilities. There is no legal requirement to document the use of restraints and seclusion and, as a result, detainees are subject to restraints and seclusion without consistent documentation in their records. In the face of overwhelming evidence that the sensory deprivation and isolation involved in seclusion can create and exacerbate mental health problems, the use of seclusion in facilities in Canada is generally prohibited unless it is necessary to prevent imminent physical harm. Yet in BC, representatives reported that restraints and seclusion are used with *Mental Health Act* detainees for many other reasons, including as a routine admission procedure, a psychiatric treatment method, a coercive tactic to elicit cooperation with involuntary psychiatric treatment, a disciplinary measure, a behaviour modification tactic, and for staff convenience.

The *Mental Health Act* and its regulations are also silent on a detainee’s right to wear clothes and rights during clothing removal. Left to the discretion of detaining facilities, detainees are generally required to remove their clothes and wear a hospital gown/pyjamas on admission. Detaining facilities treat clothing not as a right, but as a privilege, and often use access to clothing as a behaviour modification method. Representatives reported that some detaining facilities even prevent detainees from wearing clothes in review panel hearings of the Mental Health Review Board. Representatives reported that forcing a detainee to participate in a legal proceeding in a hospital gown/pyjamas contributes to the already

<sup>8</sup> At the time this report is published there is a pending *Charter* challenge regarding the use of solitary confinement, newly introduced federal legislation regarding solitary confinement, and substantial media coverage on the topic: see *British Columbia Civil Liberties Association and The John Howard Society of Canada v. Attorney General of Canada*, Notice of Civil Claim, Vancouver Registry, No. S-167325 (B.C.S.C.), and Kathleen Harris, “Liberals set 15-day limit on solitary confinement of federal prisoners”, CBC News (19 June 2017), online: <<http://www.cbc.ca/news/politics/corrections-solitary-confinement-segregation-1.4167555>>.

<sup>9</sup> *Mental Health Act*, s. 32.

significant stress, indignity, and feelings of powerlessness for detainees and can interfere with the fairness of a review panel hearing by conveying an immediate impression to the panel members before the hearing even begins that the detainee is not ready for discharge. Finally, unlike other detained populations in Canada, detainees have no right to same sex clothing removal. Representatives reported that female detainees routinely have their clothes removed by male health care providers or male private security guards, an experience that can be frightening for any woman, but can be traumatizing for women who have experienced sexual violence.

The constitutional duty to provide detainees with information on their legal rights is triggered immediately on detention. Section 3 | [Access to Information and Legal Advice](#) considers the provision of rights information on detention and issues of communication and access to information for detainees. Although everyone is constitutionally entitled to a lawyer without delay when they are detained, there is no legal aid funding or structure for detainees to access independent legal advice on detention. Unlike other Canadian jurisdictions, detainees in BC are currently provided with legal rights information by the same health care providers who are responsible for and involved in their detention — doctors, nurses, case managers, and social workers. There is widespread evidence that tasking health care providers with providing legal rights information is not functioning for either health care providers or detainees. Health care providers lack the necessary education, training, time, and independence to fulfill these obligations. Detainees cannot freely ask questions about their rights and seek legal advice from the same individuals who are actively monitoring and documenting their behaviour when those questions may form a part of the basis for further detention and involuntary psychiatric treatment.

When you are detained in mental health facilities, detaining facility staff have absolute control over your ability to communicate with people outside the facility, see visitors, and access information through cell phones, landlines, correspondence, or computers. Unlike many other Canadian jurisdictions, the BC *Mental Health Act* and its regulations do not address topics like detainees' rights to communicate with people outside the facility, detainees' right to see their advocate or lawyer or any personal visitors, and detainees' privacy rights. The ability to speak freely and privately with your legal representative is a fundamental cornerstone in a fair and transparent legal system which we solicitously protect with solicitor-client privilege. But in the absence of clear statutory direction, representatives reported many situations in which detainees have been denied access to their legal representative and have had their solicitor-client privilege breached by the facility staff responsible for their detention.

In BC, all detainees are deemed to consent to any form of psychiatric treatment, and once detained, psychiatric treatment may be forcibly administered. Section 4 | [Psychiatric Treatment](#) explores what psychiatric treatment consists of, the impacts of the deemed consent model, how psychiatric treatment is documented and authorized, and the absence of effective oversight of psychiatric treatment. BC's deemed consent model permits treating physicians to make psychiatric treatment decisions unilaterally, without assessing whether a detainee is capable of making his own treatment decisions and without recourse to any other decision maker. Representatives reported many negative impacts of forced psychiatric treatment, including increased feelings of helplessness and fear, failure to involve individuals in an autonomous and collaborative recovery plan, adversarial relationships between individuals and mental health care professionals, and minimization and disregard of the expertise of individuals and their families and friends in reporting side effects and experiences with psychiatric treatment. Canadian jurisdictions take many different approaches to psychiatric treatment for individuals in mental health detention, but BC is the only jurisdiction that operates on a deemed consent model. While there are many divergent

opinions on which model of psychiatric treatment is most effective, it is widely recognized that the BC deemed consent model does not comply with the rights guaranteed by the *Charter* and the UN CRPD.

There is no built in oversight or review of the safety or efficacy of psychiatric treatment administered to detainees and no legal mechanism for detainees to challenge psychiatric treatment administered to them against their will. The only option available to detainees who are concerned with their psychiatric treatment is to request a second medical opinion on the appropriateness of the treatment. There is no time limit for the opinion to be completed and the challenged psychiatric treatment may continue while the opinion is arranged. Representatives reported that physicians completing the second medical opinion do not consistently examine the detainee in person, but instead rely only on conversations with the treating physician and a chart review. A copy of the completed opinion is often not provided to the detainee. While the legal framework is structured to ensure that physicians who are not associated with the detaining facility have authority and access to conduct independent second medical opinions, representatives reported that second medical opinions are almost always completed by physicians who are colleagues of the treating physician at the detaining facility. Second medical opinions almost never differ from the course of treatment administered to detainees, and even when they do, there is no legal obligation on the treating physician to change the treatment. Second medical opinions are completely inadequate to operate as the only procedural safeguard to the significant deprivations of liberty and security of the person involved in forced psychiatric treatment.

In theory, detainees have several legal options to challenge their detention, but in practice the only mechanism detainees have access to is a review panel held by an administrative tribunal, the Mental Health Review Board. Section 5 | [Scheduling and Preparing for a Review Panel Hearing](#) considers the problems of health care providers attempting to interfere with detainees' right to request a review panel hearing, the law and policy regarding scheduling, postponements, and cancellation of review panel hearings, and the barriers to adequate and timely disclosure of records to prepare for a review panel hearing. Unlike other Canadian jurisdictions, BC does not have any automatic periodic reviews of ongoing detention, but instead places the onus on the detainee to initiate a review. Only a small fraction of *Mental Health Act* detentions are subject to independent review. For example, while there were over 20,000 detentions in BC in the 2015-16 fiscal year, in 2016 the Mental Health Review Board received 2152 applications for review panels and only 740 proceeded to hearing.

While there are a number of reasons detainees do not request a review panel or cancel a scheduled review panel, it is clear that health care providers have a significant influence on detainees' ability to learn about and exercise their legal rights. Representatives reported that many health care providers use tactics, such as offering inducements, making threats, exerting pressure, and actively interfering with detainees seeking review of their detention. For example, health care providers have offered to place detainees on extended leave or to grant detainees privileges, such as clothing access or day passes to the community, in exchange for cancelling their hearing. Health care providers have threatened to prolong detention or revoke privileges if a detainee goes ahead with a scheduled hearing. Health care providers have told detainees that they are wasting everyone's time in requesting a review panel and that they should cancel their hearing. The efforts to interfere with detainees' right to review detention are particularly alarming in BC, where detainees must rely on health care providers for legal rights information on detention and detention renewal. Review of detention is not only a constitutional requirement of any detention system, it can also be an important and therapeutic experience for detainees to present their perspective. Tactics used to prevent access to review panels are a disturbing interference of detainees' access to justice.

The *Mental Health Act* states that detainees are entitled to a hearing by a review panel during every period of certification.<sup>10</sup> However, the Mental Health Review Board has created a rule that a detainee who withdraws a request for a review panel is precluded from a hearing during that certification period and must instead wait until the detention is renewed to request a review panel hearing. While the Mental Health Review Board has the power to control its own process and make rules and orders respecting practice and procedure at review panel hearings, it does not have authority to abrogate a right guaranteed by statute. In the current mental health detention system, many detainees are pressured into cancelling their review panel hearings by the health care providers responsible for their detention. The Mental Health Review Board has precluded detainees who have cancelled a hearing from requesting a hearing until the next certification period based solely on the consideration of the costs involved for the tribunal. In a free and democratic society, the government's interests in reducing a tribunal's operating costs cannot outweigh the significant constitutional rights at stake for detainees who are deprived of their liberty and all of the consequences that flow from being detained under the *Mental Health Act*.

It is a fundamental component of any legal process that parties must disclose relevant evidence to each other in advance of a hearing. To ensure a legal proceeding is fair, you are entitled to know the case that you have to meet at the hearing and have an opportunity to prepare your response. In the administrative system for *Mental Health Act* detentions, detaining facilities and mental health teams have a legal obligation to disclose all relevant records in their possession prior to a hearing. Unfortunately, staff at detaining facilities and mental health teams routinely fail to comply with their legal obligations to provide detainees with timely and fulsome disclosure of relevant records, which jeopardizes the fairness of review panel hearings. Representatives were unanimous in reporting that they had encountered issues with disclosure from detaining facilities and mental health teams, ranging from a complete refusal to disclose records in advance of a hearing, to elaborate demands being imposed on representatives in order to gain access to records, to documents being disclosed with inappropriate redactions. Detaining facilities and mental health teams often present records and evidence for the first time at review panel hearings. The Mental Health Review Board has a responsibility to ensure that evidence is only admitted and relied on at review panel hearings if detainees and their legal representatives have had sufficient time to review and prepare for the case to be met.

Review panel hearings are an opportunity to conduct an independent review of the state's case for detention and for detainees to present their case for discharge. Section 6 | [Review Panel Hearings and Decisions](#) discusses issues relating to the composition of panels, procedural fairness issues at review panel hearings, and review panel decisions. The right to an impartial decision maker is a necessary component of a fair hearing. However, unlike other Canadian jurisdictions, the BC *Mental Health Act* and its regulations do not have protections against conflict of interest, bias, or apprehension of bias among review panel members. The Mental Health Review Board Rules of Practice and Procedures are similarly silent on the topic. Representatives reported several panel composition issues that raise significant concerns for bias and the apprehension of bias, including the appointment of the same panel members to multiple consecutive panels for the same detainee and review panels that took place despite connections between panel members and the parties.

Although not set out in the *Mental Health Act*, the *Mental Health Regulation*, or its Rules of Practice and Procedures, the Mental Health Review Board funds detaining facilities to participate in review panel proceedings by compensating the treating physician for preparing a report and presenting the state's case for detention at the hearing. However, the Mental Health Review Board does not fund detainees to

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<sup>10</sup> *Ibid*, s. 25.

participate in review panel hearings. For example, the Board will not provide detainees with funds to hire a lawyer to represent them at a hearing, reimburse witnesses for travel expenses, or retain an independent physician to conduct an examination and present medical evidence at a hearing. For a tribunal to function as an independent and impartial decision maker, it must treat all parties that appear before it in a fair and equivalent manner. The asymmetrical funding of parties who participate in review panel proceedings has a significant detrimental impact on a detainee's right to a fair hearing.

Reports from representatives demonstrate that review panel procedures are inconsistent and vary depending on which members the review panel is composed of. Representatives raised several concerns in relation to panel member conduct that compromise the procedural fairness of hearings and makes detainees feel as if they have not had the opportunity to be listened to in a dignified and respectful proceeding. Representatives also reported that review panel decisions are not consistent and predictable, but instead vary depending on the composition of the review panel. There are several deficiencies in the adequacy of reasons for review panel decisions, including unbalanced references to the parties' evidence and arguments, failure to adequately weigh and resolve conflicts in relevant evidence, and insufficient legal analysis and interpretation of the law. Many of these issues could be addressed with improved transparency from the Mental Health Review Board in developing and publishing rules, policies, guidelines, practice directions, or anonymized decisions. In addition, the one to two days of training review panel members receive is wholly inadequate to equip members to fulfill their duties in conducting fair hearings to adjudicate the deprivation of an individual's liberty, especially in light of the significant rights deprivations that flow from detention.

Finally, section 7 | **Oversight and Accountability** will consider the oversight and accountability mechanisms in place to ensure the exercise of such extraordinary power in the mental health detention system is adequately monitored and evaluated. The jurisdiction of the Mental Health Review Board is limited to one legal issue: determining whether the detention of the patient should continue because the legal criteria for detention continue to describe the condition of the patient. Detainees have no way to seek review from the Mental Health Review Board of any other issue that affects them, such as facility placement, conditions of leave from facilities, forced psychiatric treatment, the use of seclusion and restraints, or the deprivation of privileges. The jurisdiction of the Mental Health Review Board is inadequate to provide the administrative oversight required by the *Charter* for such significant rights deprivations. Although there are several options for detainees to seek review of their detention in BC Supreme Court, in the absence of legal aid structures for detainees to pursue these mechanisms, detainees are currently not able to access the Court. Despite the thousands of people involuntarily detained every year in BC, there have only been two published judgments resulting from detainees challenging their detention since the last significant amendments were made to the *Mental Health Act* in 1998.

Besides its Rules of Practice and Procedures, the Mental Health Review Board does not publish policies, guidelines, practice directions, accountability documents, or annual reports. As the goal for any administrative system is fair and transparent functioning, the absence of published information is unusual for a tribunal. The Mental Health Review Board is in breach of its legal obligation to produce an annual report detailing, among other things, the tribunal's operations, performance indicators, details on the nature and number of applications and other matters received or commenced by the tribunal, trends, and plans for improving the tribunal's operations in the future.<sup>11</sup> The Ministry of Health does not have comprehensive and current data on straightforward components of the mental health detention system, such as the number of detentions broken down by facility, geographic region, or health authority and the average

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<sup>11</sup> *Administrative Tribunals Act*, S.B.C. 2002, c. 45, s. 59.2.



**The only way to address these deeply entrenched flaws is to shine a bright and intense light on the system of *Mental Health Act* detention. The *Mental Health Act* detention system does not just need a few amendments or tweaks, it needs to be overhauled.**

length of detention periods. The conclusion to be drawn from the failure to track and monitor this data is that the health authorities and the Ministry of Health have not been engaging in adequate oversight or evaluation of the system for mental health detention in BC.

While other Canadian jurisdictions have appointed an independent provincial Mental Health Advocate and commissioned investigations to evaluate whether their mental health detention systems are functioning effectively and minimally impairing the rights of those impacted, the BC Government has failed to review the administrative system for *Mental Health Act* detention and involuntary psychiatric treatment. Although the BC Government established a provincial Mental Health Advocate in 1998, the role was eliminated in 2001, despite an external evaluation that concluded the office should be retained. The Office of the Ombudsperson has the mandate in BC to investigate whether provincial public authorities have acted fairly and reasonably. The last published systemic investigation that considered mental health detention in depth was conducted in 1994. In the absence of systemic investigations from the BC Government, the Ombudsperson, or an independently appointed advocate, the onus is on individuals to initiate and sustain a complaint following a negative experience with mental health detention.

BC's system of *Mental Health Act* detention is operating in darkness. The rights violations and procedural unfairness identified throughout this report have flourished in the absence of systemic oversight and evaluation. BC has fallen far behind other Canadian jurisdictions on numerous measures — our substantive law is not constitutionally compliant, our procedures are inadequate to provide effective safeguards, and our systemic review efforts are virtually non-existent. The *Mental Health Act*, *Mental Health Regulation*, and administrative detention processes do not comply with the rights guaranteed by the *Charter* and the UN CRPD.

The only way to address these deeply entrenched flaws is to shine a bright and intense light on the system of *Mental Health Act* detention. The *Mental Health Act* detention system does not just need a few amendments or tweaks, it needs to be overhauled. The BC Government should establish an independent law reform commission to critically analyse the current system and point us towards a transparent system that fulfills the rights guaranteed in the *Charter* and the UN CRPD. Finally, given the longstanding failures of the responsible authorities in proactively monitoring themselves, the BC Government should appoint a provincial Mental Health Advocate who is independent of any government ministry and reports directly to the legislative assembly. In the last 15 years since the Mental Health Advocate's role was abruptly eliminated, our mental health system has stagnated in the dark. The appointment of a provincial Mental Health Advocate to act as an independent watchdog would demonstrate the BC Government's commitment to move forward to a mental health system that fulfills the principles of dignity, equality, and self-determination.



# 1 | Detention Decisions

## OVERVIEW

It is a common misconception that people must be considered a danger to themselves or others to be involuntarily detained in BC. The *Mental Health Act* in fact permits detention in a much broader range of circumstances.

**IT IS A COMMON MISCONCEPTION** that people must be considered a danger to themselves or others to be involuntarily detained in BC. The *Mental Health Act* in fact permits detention in a much broader range of circumstances. Physicians are authorized to make detention decisions by completing certificates set out in the *Mental Health Regulation*. Each certificate for involuntary detention must set out the written reasons of a physician who has examined the person and is of the opinion that the individual meets all of the following criteria for detention:

- 1) The person has a disorder of the mind that requires safe and effective psychiatric treatment and seriously impairs the person's ability to react appropriately to the person's environment, or to associate with others;
- 2) The person requires safe and effective psychiatric treatment in or through a designated facility;
- 3) The person requires care, supervision and control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the protection of the person or the protection of others; **and**
- 4) The person cannot suitably be admitted as a voluntary patient.<sup>12</sup>

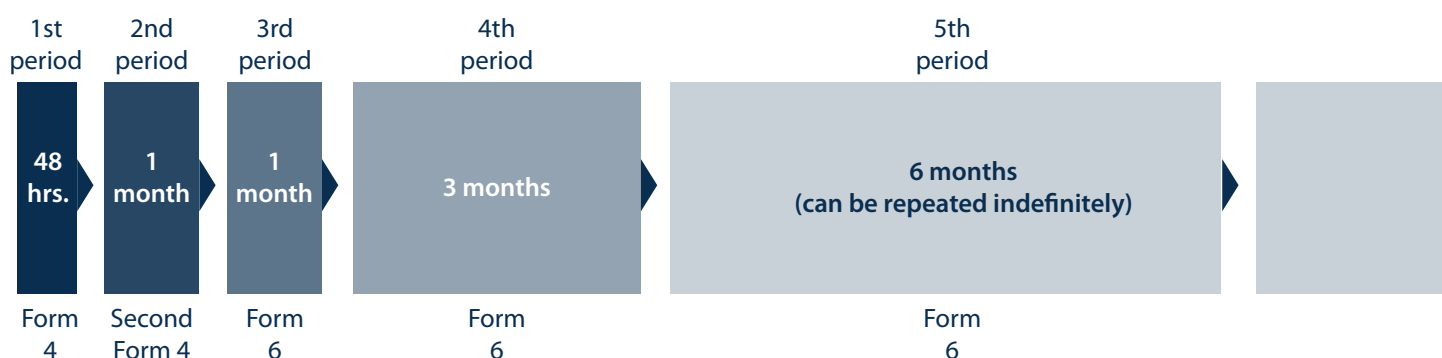
The first certificate a physician completes is a Form 4, which provides authority for anyone to apprehend the individual and to transport him to a designated facility for admission and detention for a 48 hour period. To detain an individual beyond the first 48 hour period, a second physician must complete a second Form 4. With two Form 4s completed, an individual can be detained for 1 month. To continue detention, a physician must complete a Form 6 to renew detention for a further one month period. The completion of a subsequent Form 6 renewal certificate extends detention for a further three month period. All following Form 6 renewal certificates extend detention for six month periods. The detention periods can be summarized as follows:<sup>13</sup>

<sup>12</sup> *Mental Health Act*, R.S.B.C. 1996 c. 288 [Mental Health Act], ss. 1, 22.

<sup>13</sup> *Ibid*, ss. 22-24.

There is no limit in the BC *Mental Health Act* on the length of involuntary detention. Individuals can be detained indefinitely on continuously renewed cycling 6 month certificates. Unlike many other Canadian jurisdictions, BC has no mechanism to ensure a minimum level of periodic automatic review of the detention takes place.

## SUMMARY OF DETENTION PERIODS



Certification Period	Certificate Required	Length of Detention Permitted
First period	One Form 4	48 hours
Second period	Second Form 4	1 month
Third period	One Form 6	1 month
Fourth period	One Form 6	3 months
Fifth period	One Form 6	6 months
All subsequent periods	One Form 6	6 months

*Mental Health Act* patients are detained in hospitals and facilities that are designated for that purpose.<sup>14</sup> A director of the mental health facility is appointed by the relevant health authority to be responsible for the operation of the facility, but in practice, many of the director's powers are delegated to other individuals, like doctors, nurses, and social workers.<sup>15</sup> Directors and their

<sup>14</sup> *Ibid*, s. 3.

<sup>15</sup> *Mental Health Regulation*, B.C. Reg. 233/99, s. 3.

Involuntary patients on extended leave must abide by conditions imposed by treating physicians (such as where to live and what treatment must be administered) and can be recalled to a designated facility at any time if they are suspected of breaching those conditions. There is no way to seek review of decisions to place or recall a detainee on extended leave or the conditions of leave imposed.

delegates have authority to place detainees on extended leave in the community or in another approved home, such as a residential care facility.<sup>16</sup> On extended leave, involuntary patients may live in their homes, return to their jobs, and go about their day to day lives, but still be subject to the rights deprivations that flow from detention. The *Mental Health Act* states that placement on extended leave does not “impair the authority for the patient’s detention under this Act and that authority may be continued, according to the same procedures and to the same extent, as if the patient were detained in a designated facility.”<sup>17</sup> Involuntary patients on extended leave must abide by conditions imposed by treating physicians (such as where to live and what treatment must be administered) and can be recalled to a designated facility at any time if they are suspected of breaching those conditions. There is no way to seek review of decisions to place or recall a detainee on extended leave or the conditions of leave imposed.

The criteria for involuntary detention is a contentious topic and many criticisms have been directed at the wide reach of the *Mental Health Act* criteria in BC.<sup>18</sup> It is beyond the scope of this report to analyze the substance of the detention criteria in the *Mental Health Act*. Such a discussion could be, and should be, the subject of its own investigation. For the purposes of this discussion on detention decisions, it is important to note that the BC *Mental Health Act* criteria are very broad and there are few procedural safeguards in place for detention decisions.

For example, there is no limit in the BC *Mental Health Act* on the length of involuntary detention. Individuals can be detained indefinitely on continuously renewed cycling 6 month certificates. Unlike many other Canadian jurisdictions, BC has no mechanism to ensure a minimum level of periodic automatic review of the detention takes place.<sup>19</sup> Unless individual detainees apply for a review panel, they can be detained for the remainder of their life without an independent review of the detention. In contrast, several other Canadian jurisdictions mandate that periodic reviews be conducted automatically. For example, Alberta’s *Mental Health Act* states that if a patient has been involuntary for six months and has not applied for review or has withdrawn an application for review, the patient is deemed to have applied to the review panel and a hearing will be held.<sup>20</sup> Concerns regarding insufficient detention reviews will be discussed in more detail in section 5 | [Scheduling and Preparing for a Review Panel](#).

<sup>16</sup> *Mental Health Act*, ss. 37, 38.

<sup>17</sup> *Ibid*, s. 39.

<sup>18</sup> British Columbia, *Equality, Dignity and Inclusion: An Evaluation of British Columbia’s Mental Health Laws, Policies and Service Standards*, by Beverly Froese, in Report to the Law Foundation of British Columbia (Victoria: 31 March 2017) at 57-58; Muriel Groves, “Suggested Changes to BC’s Mental Health System regarding Involuntary Admission and Treatment in Non-Criminal Cases” (2011), online: <<https://bcccla.org/wp-content/uploads/2013/01/2012-BCCLA-Paper-BC-Mental-Health-System.pdf>> at 2.

<sup>19</sup> Although the Mental Health Review Board Chair may order a hearing pursuant to s. 25(1.1) of the *Mental Health Act* if a patient has been on leave or transferred to an approved home under section 37 or 38 for 12 or more consecutive months without requesting or having a review panel hearing, this provision only applies to patients on extended leave, not those detained in inpatient settings. Even among extended leave patients, hearings are by no means automatic, since the facility director could fail to notify the Mental Health Review Board Chair or the Chair could decide not to order a hearing if she is not satisfied that there is a reasonable likelihood of discharge.

<sup>20</sup> R.S.A. 2000, c. M-13 [Alberta *Mental Health Act*], s. 39(1).

In addition, the BC *Mental Health Act* permits indefinite detention with no independent oversight of the conditions of detention. The Mental Health Review Board has no jurisdiction to consider rights deprivations that flow from detention, such as facility placement, forced psychiatric treatment, the use of seclusion and restraints, or the denial of liberties that facilities consider “privileges”. In *P.S. v. Ontario*,<sup>21</sup> the Ontario Court of Appeal unanimously ruled that it was a violation of the *Charter* to allow indefinite detention without sufficient oversight to ensure a patient’s liberty is not unnecessarily restricted. The Court held that s. 7 of the *Charter* requires that the body reviewing detention be given the procedures and powers necessary to render a decision that is minimally restrictive on liberty in light of the circumstances necessitating the detention.<sup>22</sup> The problems created by inadequate jurisdiction to review conditions of detention will be discussed in more detail in section 7 | [Oversight and Accountability](#).

It is also important to note that while in many areas of law the level of state intervention on an individual’s liberty and security has generally been decreasing over time and procedural safeguards that ensure fairness when those interventions occur have, correspondingly, been increasing, involuntary mental health detention has followed the opposite trajectory. The last significant amendments to the BC *Mental Health Act* passed in 1998 expanded the criteria for detention and reduced the procedural checks and balances involved in detention decisions.<sup>23</sup> Before 1998, the *Mental Health Act* only permitted detention when it was necessary for “the person’s own protection or for the protection of others”, but the amendments broadened the criteria to permit detention to prevent the person’s “substantial mental or physical deterioration”. The requirement for two physicians to complete the initial certificate was reduced to one physician. The safeguards in place to ensure independence between certifying physicians were repealed. Robust protections against liability were added for physicians who make detention decisions to ensure that they are under no apprehension of any legal consequences for deciding to detain or not detain an individual. In short, our current legislative system is designed to make involuntary detention easy.

Given the broad criteria and minimal procedural fairness involved in detention decisions, it is unsurprising that the number of involuntary detentions has been rising in BC. Data obtained through a Freedom of Information request submitted to the Ministry of Health for the purposes of this research reveals precisely that.<sup>24</sup> While data tracking mechanisms are incomplete, available data indicates involuntary admissions have risen from at least 11,937 to 20,008 per year over the last ten years. What is surprising from this data, however, is that while involuntary admissions have been steadily increasing over the last decade, the number of voluntary admissions has remained virtually unchanged. Voluntary admissions have gone from 17,659 to 17,060 per year over the same ten year period.

When the *Guide to the Mental Health Act* was published in 2005, the author wrote that based on 2003 statistics, “[m]ost people in British Columbia requiring hospital treatment for mental disorders are voluntarily admitted to hospital, just like people with other illnesses.”<sup>25</sup> As the data below demonstrates, this is no longer true — involuntary admissions now outnumber voluntary admissions. Given that the number of all admissions should have increased with population growth, the complete stagnation of voluntary admissions in the face of increasing involuntary admissions indicates that our mental health system now

21 2014 ONCA 900.

22 *Ibid* at para. 92.

23 Bill 22, *Mental Health Amendment Act*, 1998, 3rd Sess., 36th Parl., British Columbia, 1998 (as amended in Committee of the Whole 29 July 1998), online: <<http://www.leg.bc.ca/36th3rd/amend/gov22-2.htm>> [*Mental Health Amendment Act*].

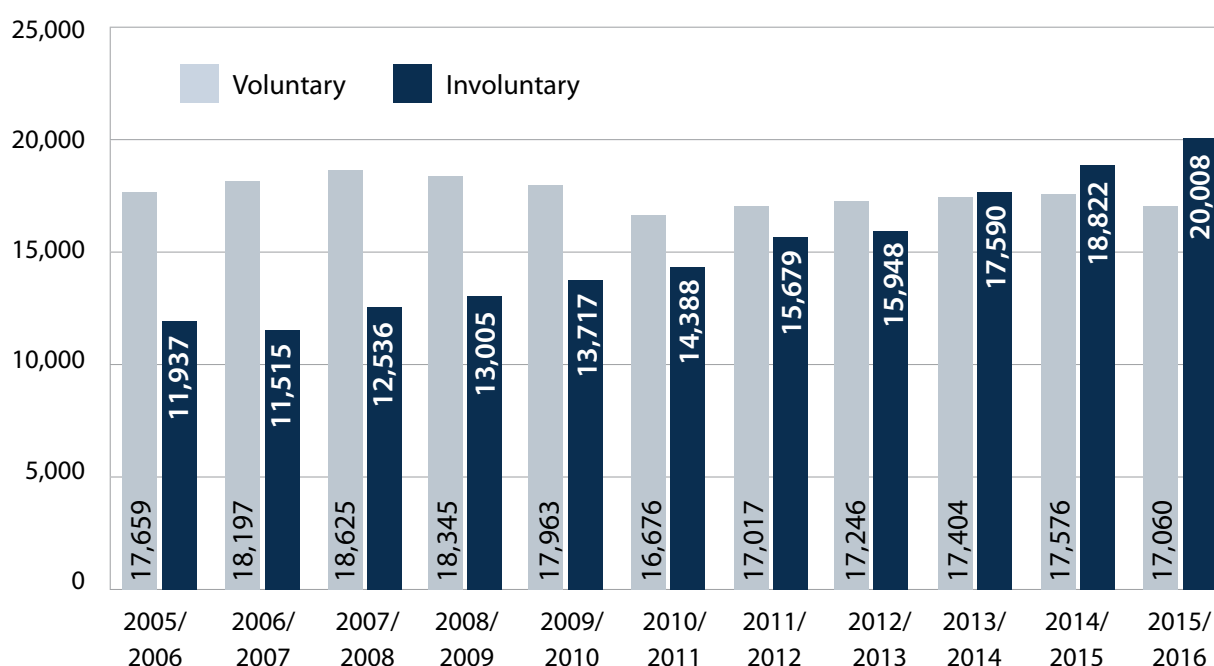
24 This data has been abbreviated for readability. See the Appendix for the full tables of data and their qualifiers released through the Freedom of Information request.

25 British Columbia, Ministry of Health, *Guide to the Mental Health Act*, 2005 edition (4 April 2005), online: <<http://www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf>> [*Guide to the Mental Health Act*] at 1.



Given that the number of all admissions should have increased with population growth, the complete stagnation of voluntary admissions in the face of increasing involuntary admissions indicates that our mental health system now predominantly interacts with people with mental health problems in an adversarial way, by removing their rights to make decisions, rather than in a voluntary way that promotes autonomy and collaboration in the recovery process.

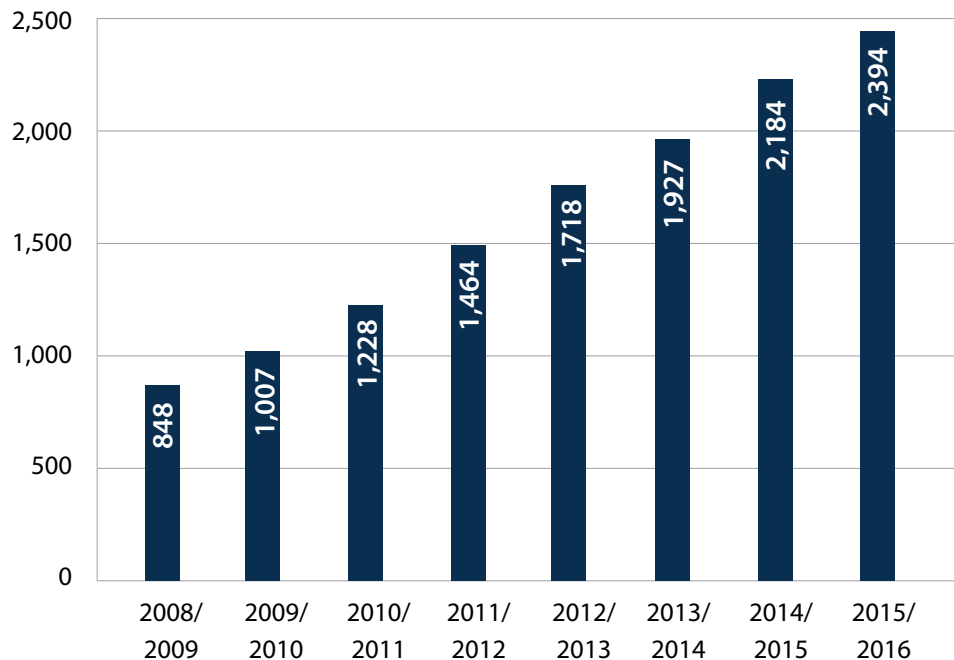
## INVOLUNTARY AND VOLUNTARY MENTAL HEALTH HOSPITALIZATIONS IN BC 2005–2016



predominantly interacts with people with mental health problems in an adversarial way, by removing their rights to make decisions, rather than in a voluntary way that promotes autonomy and collaboration in the recovery process.

Another interesting finding in the data obtained from the Freedom of Information request submitted to the Ministry of Health is that the use of the *Mental Health Act*'s extended leave provisions has increased dramatically. The number of detainees placed on extended leave has nearly tripled in the eight years that the Ministry of Health has been tracking the data. As many mental health facilities do not report when a detainee is placed on extended leave and this data does not reveal how long individuals are kept on extended leave, it is an incomplete picture of the full extent of extended leave use. Advocates and lawyers have represented individuals who have been detained for prolonged periods on extended leave — sometimes as long as 10 years — which will be discussed in more detail in the following section.

## NUMBER OF PATIENTS RELEASED ON EXTENDED LEAVE IN BC 2005–2016



The number of detainees placed on extended leave has nearly tripled in the eight years that the Ministry of Health has been tracking the data.

This section will begin with a discussion on how detention decisions are made, including the completion of Form 4s and 6s, consistent and appropriate applications of the criteria, and observations of issues associated with the application of specific criteria. The section will then consider the minimum qualification levels and safeguards in place for those making detention decisions. Finally, the section will conclude by considering discharge decisions for detainees who no longer meet the legal criteria for detention.

## APPLICATION OF CRITERIA FOR DETENTION AND RENEWAL

When physicians examine individuals to decide whether they meet the criteria for detention pursuant to the *Mental Health Act*, they are acting as administrative decision makers on behalf of the state. Section 10(a) of the *Charter* provides that on detention, everyone has the right to be informed promptly of the reasons for detention. The certificates that physicians complete to enforce detention pursuant to the *Mental Health Act* cannot simply contain vague or general references to the statute's criteria. The certificates must provide sufficient application of the legal criteria to the facts of the individual's circumstances to permit the individual and any other person on review to understand the reasons why the decision maker concluded the criteria were met.

The significance of providing adequate reasons for mental health detention was underscored in the recent decision of the Newfoundland and Labrador Court of Appeal, *Abbass v. The Western Health Care Corporation*.<sup>26</sup> On April 7, 2015 police officers came to Mr. Abbass's home to detain him for an involuntary mental health assessment after Mr. Abbass made certain tweets on Twitter "which potentially expressed

<sup>26</sup> 2017 NLCA 24.

anger relating to a recent shooting of an individual by a policeman.”<sup>27</sup> Two physicians completed certificates to detain Mr. Abbass under the province’s *Mental Health Care and Treatment Act*<sup>28</sup> based on the information repeated to them by the police. Mr. Abbass challenged the legality of his detention by way of a *habeas corpus* application.

In a unanimous judgment, the Court of Appeal made a resounding critique of the reasons for detention provided by the certifying physicians:

[37] Both certificates primarily contain a recitation of the circumstances (presumably relayed by others because they did not lie within the physicians’ personal knowledge) under which Mr. Abbass was brought in for assessment. Aside from asserting, as part of the pre-printed form, that he suffers from a “mental disorder” the certificates make no attempt to identify the mental disorder in question (except, possibly, in the case of the first certificate, that there are some symptoms “consistent with paranoia”) and certainly do not set out any “facts” within the physicians’ own knowledge (such as observations, interactions or answers to questions) that in the words of section 17(1)(c) are the facts “upon which the person who has conducted the psychiatric assessment has formed the opinion”. Certainly, the generalized references to personal and public safety and anger as well as the need for further observation and assessment cannot constitute the “facts” contemplated by section 17(1)(c) without showing that by virtue of their significance and nature they relate to and meet the criteria of harm to oneself or others and inability to appreciate the nature and consequences of the mental disorder (assuming one was specifically identified) or to make an informed decision regarding treatment, as set out in section 17(1)(b)(ii)(A)-(C).

[38] The certificate is not merely a piece of paper that evidences a decision that has been made. It is the authority in itself to intrude upon the liberty and privacy of an individual. Without the existence of the piece of paper, properly completed, the authority does not exist. ...

[Emphasis added.]

The Court also articulated the importance of police and physicians conscientiously applying the detention criteria and the risk of misuse of the significant powers to involuntarily detain an individual for mental health assessment and treatment:

[51] If anger about political events and words of defiance to authorities are dealt with as signs of mental illness, a fortiori mental illness warranting involuntary committal, then our society is in a dangerous place. Such anger and defiance are characteristic of political dissent. As the history of authoritarian societies has taught us, confinement in a mental institution is a particularly insidious way of stifling dissent, directly and through intimidation. Was this the intent of the police in this case? Did the physicians simply lend their authority to what the police asked them to do? Did they assume that a person who acts in the way Mr. Abbass did needs help and further assessment and observation, without turning their minds to the specific limited statutory criteria that would justify his deprivation of liberty? ...

[52] The reality is that if you are involuntarily confined, you are viewed differently; you are seen as less credible. That is not how it should be but that is how it is. ...

[Emphasis added.]

<sup>27</sup> *Ibid* at para. 6.

<sup>28</sup> S.N.L. 2006, c. M-9.1.

## IN THE WORDS OF THE LEGAL REPRESENTATIVES:

*"I had one case where there was like two words on [the Form 4] that you couldn't read — that was all they filled out. And I think it's just a stamp — they just sign it — they write the same thing on a lot of them. They don't outline specifically what this person has usually, and when they do it's just like a rubber stamp of the same thing every time."*

## REPRESENTATIVES REPORTED

### Completion of Certificates for Detention

Representatives reported many concerns about the reasons for detention physicians provide in completing the certificates for detention and renewal pursuant to the BC *Mental Health Act*. Several representatives pointed out that they often could not read what physicians had written on the Form 4s or 6s because the certificates were completed by hand and the writing was illegible or the copies were poor quality. Representatives reported that Form 4s and 6s were frequently completed in a brief, general, and haphazard manner. Representatives gave examples of complete reasons for detention consisting of a few words or sentences, such as "no insight" or "psychosis, non-compliant with meds". Some representatives reported seeing two Form 4s that had identical or nearly identical wording, raising the concern that the second certifying physician did not exercise independent judgment in applying the detention criteria. Others reported seeing Form 6 renewal certificates with identical or nearly identical wording. This indicates that physicians had not completed the necessary reassessment to make a fresh decision on the basis of the legal criteria, as there would likely be changes to assess over the course of a period as long as 6 months.

The predominant observation repeated by many representatives was that there was usually no way of knowing from the reasons on the certificates whether the physicians who made detention decisions considered the legal criteria and applied them to the specific facts for the individual.

*"I had one case where there was like two words on [the Form 4] that you couldn't read — that was all they filled out. And I think it's just a stamp — they just sign it — they write the same thing on a lot of them. They don't outline specifically what this person has usually, and when they do it's just like a rubber stamp of the same thing every time."*

*"Sometimes I can't tell the name of who signed it, I can't tell their reasons, the writing is often — you know, it's a doctor and doctors' writing can be scribbly as all of ours can be — but the quality of the copies goes down ... and I'd say the vast majority of the time I can't tell what the reasons for detention were simply by looking at the Form 4s."*

### Consistent and Appropriate Application of Criteria

Representatives reported that, for the most part, detention decisions appeared to adhere to the criteria set out in the *Mental Health Act*, however, the breadth of the criteria and the approach of physicians resulted in a wide net of detentions. They explained that when there is any doubt about whether an individual meets the detention criteria, physicians tend to err on the side of detaining. Most understood the over

FORM 4s: Redacted examples of poorly completed Form 4s provided by representatives that do not give adequate reasons to explain how the physician applied the legal criteria for detention to the individual.

**FORM 4**  
**MENTAL HEALTH ACT**  
[ Sections 22, 28, 29 and 42,  
R.S.B.C. 1996, c. 288 ]

**MEDICAL CERTIFICATE**  
**(VOLUNTARY ADMISSION)**

I, \_\_\_\_\_, M.D., certify that I examined  
physician's name (please print)

\_\_\_\_\_ on 01/01/2017.  
first and last name of person examined (please print) dd / mm / yyyy

1. In my opinion, this person:  
has a disorder of the mind that requires treatment and which seriously impairs the person's ability to react appropriately to his/her environment or to associate with others (section 1 of the *Mental Health Act*);

In summary form, the reasons for my opinion are: (information may be obtained through interviews, observations and collateral sources)  
\_\_\_\_\_ is present & is acting bizarre. He requires 3 months.

2. In my opinion, this person:

(a) requires treatment in or through a designated facility; and

(b) requires care, supervision and control in or through a designated facility to prevent his/her substantial mental or physical deterioration or for the protection of the person or for the protection of others; and

(c) cannot suitably be admitted as a voluntary patient.

This person ☐ was ☒ was not brought to me by a police officer or constable under section 28 of the Act.

Signed \_\_\_\_\_  
physician's address (please print)

Note: if above space is insufficient, continue on back of form

01/01/2017  
date of signature (dd / mm / yyyy)

\_\_\_\_\_ telephone

Note: This medical certificate, when duly signed, is authority for anyone to apprehend the person who is the subject of this certificate and to transport the person to a designated facility for admission and detention for a 48 hour period. If a second medical certificate is completed within that period, it provides authority to detain the person for one month from the date of admission under the first certificate.

If this is a first medical certificate, it becomes invalid on the 15th day after the date upon which the physician examined the person who is the subject of the certificate unless the person has been admitted on the basis of it.

HLT 3504 Rev. 2005/08/01 (PINK)



FORM 4  
MENTAL HEALTH ACT  
[ Sections 22, 28, 29 and 42,  
R.S.B.C. 1996, c. 288 ]

MEDICAL CERTIFICATE  
(INVOLUNTARY ADMISSION)

I, \_\_\_\_\_, M.D., certify that I examined  
\_\_\_\_\_,  
physician's name (please print)  
\_\_\_\_\_,  
first and last name of person examined (please print) on 10/10/2013  
dd / mm / yyyy

In summary form, the reasons for my opinion are: (information may  
be obtained through interviews, observations and collateral sources)

1. In my opinion, this person:

has a disorder of the mind that requires  
treatment and which seriously impairs  
the person's ability to react appropriately  
to his/her environment or to associate  
with others (section 1 of the *Mental  
Health Act*);

Psychosis

Risk harm to self

2. In my opinion, this person:

- (a) requires treatment in or through a  
designated facility; and
- (b) requires care, supervision and  
control in or through a designated  
facility to prevent his/her substantial  
mental or physical deterioration or  
for the protection of the person or  
for the protection of others; and
- (c) cannot suitably be admitted as a  
voluntary patient.

This person ☒ was ☐ was not  
brought to me by a police officer or  
constable under section 28 of the Act.

Note: if above space is insufficient, continue on back of form

Signed \_\_\_\_\_  
physician's signature  
\_\_\_\_\_  
physician's address (please print)  
\_\_\_\_\_  
telephone  
10/10/2013  
date of signature (dd / mm / yyyy)

**Note:** This medical certificate, when duly signed, is authority for anyone to apprehend the person who is the subject of this certificate and to transport the person to a designated facility for admission and detention for a 48 hour period. If a second medical certificate is completed within that period, it provides authority to detain the person for one month from the date of admission under the first certificate.

If this is a first medical certificate, it becomes invalid on the 15th day after the date upon which the physician examined the person who is the subject of the certificate unless the person has been admitted on the basis of it.

## FORM 6: Redacted examples of poorly completed Form 6s provided by representatives.

These two certificates were completed 4 months apart for the same detainee. The reasons were not only inadequate to explain how the physician applied the legal criteria, but the wording is virtually the same on both forms and does not reflect a fresh assessment that considers any changes that have occurred in the intervening 4 months.

**FORM 6**  
**MENTAL HEALTH ACT**  
(Section 24, R.S.B.C. 1996, c. 288)

**MEDICAL REPORT ON EXAMINATION OF INVOLUNTARY PATIENT**  
(RENEWAL CERTIFICATE)

I, [redacted], M.D., being a physician and the  
name of physician (please print)  
director of, or a physician authorized by the director of, [redacted]  
name of designated facility

certify that on 25/11/2013 examined [redacted]  
dd / mm / yyyy first and last name of patient (please print)

who on 07/10/2013 was admitted as an involuntary patient to [redacted]  
dd / mm / yyyy name of designated facility

On the basis of my examination, and having taken into consideration the requirements of section 24 (2.1)\* of the  
Mental Health Act, I have formed the opinion that: (1) sections 22 (3) (a) (i) and (c)\*\* of the Act continue to describe  
the condition of the patient; and (2) that this patient's status as an involuntary patient should be renewed.

The patient's status as an involuntary patient is renewed for a period of up to three (3)  
number of month(s)

The patient must be examined again on or before 06/03/2014, the date on which this renewal  
dd / mm / yyyy  
expires. The reasons that lead me to form the above opinion are:

It has ongoing delusion. She  
has poor insight into her problem.

[redacted]  
signature of physician

Note: If above space is insufficient, continue on back of form

25/11/2013  
dd / mm / yyyy

Notes:  
\* Section 24 (2.1) requires that the physician's examination must include:  
(a) consideration of all reasonably available evidence concerning the patient's history of mental disorder including (i) hospitalization for  
treatment, and (ii) compliance with treatment plans following hospitalization, and  
(b) an assessment of whether there is significant risk that the patient, if discharged, will as a result of mental disorder fail to follow the  
treatment plan the director or physician considers necessary to minimize the possibility that the patient will again be detained under  
section 22.  
\*\* Section 22 (3) of the Act states the following involuntary admission criteria:  
The patient is a person with a mental disorder who (i) requires treatment in or through a designated facility, (ii) requires care, supervision and  
control in or through a designated facility to prevent the patient's substantial mental or physical deterioration or for the protection of the patient  
or the protection of others, and (iii) cannot suitably be admitted as a voluntary patient.

MLHA 2009 Rev. 2005/06/01

**FORM 6**  
**MENTAL HEALTH ACT**  
(Section 24, R.S.B.C. 1996, c. 288)

**MEDICAL REPORT ON EXAMINATION OF INVOLUNTARY PATIENT**  
(RENEWAL CERTIFICATE)

I, [redacted], M.D., being a physician and the  
name of physician (please print)  
director of, or a physician authorized by the director of, [redacted]  
name of designated facility

certify that on 04/03/2014 examined [redacted]  
dd / mm / yyyy first and last name of patient (please print)

who on 07/10/2013 was admitted as an involuntary patient to [redacted]  
dd / mm / yyyy name of designated facility

On the basis of my examination, and having taken into consideration the requirements of section 24 (2.1)\* of the  
Mental Health Act, I have formed the opinion that: (1) sections 22 (3) (a) (i) and (c)\*\* of the Act continue to describe  
the condition of the patient; and (2) that this patient's status as an involuntary patient should be renewed.

The patient's status as an involuntary patient is renewed for a period of up to six  
number of month(s)

The patient must be examined again on or before 06/09/2014, the date on which this renewal  
dd / mm / yyyy  
expires. The reasons that lead me to form the above opinion are:

It has diagnosis of schizoaffective  
disorder. She has poor insight

[redacted]  
signature of physician

Note: If above space is insufficient, continue on back of form

04/03/2014  
dd / mm / yyyy

Notes:  
\* Section 24 (2.1) requires that the physician's examination must include:  
(a) consideration of all reasonably available evidence concerning the patient's history of mental disorder including (i) hospitalization for  
treatment, and (ii) compliance with treatment plans following hospitalization, and  
(b) an assessment of whether there is significant risk that the patient, if discharged, will as a result of mental disorder fail to follow the  
treatment plan the director or physician considers necessary to minimize the possibility that the patient will again be detained under  
section 22.  
\*\* Section 22 (3) of the Act states the following involuntary admission criteria:  
The patient is a person with a mental disorder who (i) requires treatment in or through a designated facility, (ii) requires care, supervision and  
control in or through a designated facility to prevent the patient's substantial mental or physical deterioration or for the protection of the patient  
or the protection of others, and (iii) cannot suitably be admitted as a voluntary patient.

MLHA 2009 Rev. 2005/06/01

inclusive application of detention decisions as being rooted in the best interests approach taken by physicians. Several representatives observed that while physicians have good intentions in making detention decisions, they often made decisions as physicians trying to do what they perceive is best for their patient, rather than as administrative decision makers applying statutory criteria. For example, one representative recounted representing a client whose treating physician kept her detained so that she would not travel home to visit her family over the holidays because the physician believed that the journey would be stressful for her. Another representative reported cross-examining a physician at a review panel who stated that she wanted to impose a healthier lifestyle on her patient by keeping her detained to ensure she did not smoke cigarettes or drink alcohol. Both detainees in these examples were released by order of the review panel because they did not meet the criteria for detention.

Many representatives expressed concern that the criteria are not applied in a consistent way across different detention decisions and that there was quite a bit of variety in how physicians interpreted the criteria. One representative reported that it was her experience that individuals with a history of certification are more likely to be detained regardless of their current mental health status. She provided an example of a woman who sought medical treatment for a physical injury who was certified because the health care providers assumed based on a history of certification that she was delusional or faking the physical health problem. Some representatives observed a paradox in that many individuals who come to hospitals seeking mental health services through voluntary admission are turned away, whereas many individuals who do not want mental health services are involuntarily admitted. These representatives observed that this trend may indicate that mental health care systems are set up in an adversarial way in which health care providers are more likely to see the need for intervention when an individual is not seeking assistance.<sup>29</sup>

Finally, several representatives raised concerns that the *Mental Health Act* was increasingly being used to detain individuals in a variety of situations that the statute was not intended to address. For example, many representatives reported an increasing number of seniors with dementia, Parkinson's disease, or physical health care problems who were detained not for mental health treatment, but because of concerns that they needed supports or services that were not available in their home environment. Some representatives reported representing female clients who were in detention as a mechanism to keep them separated from an abusive man, such as their intimate partner or adult son. Several representatives reported that they had represented individuals who were detained for substance use problems, whose detention appeared to be a way to enforce sobriety on the individual during the period of detention without providing any drug and alcohol treatment. Some representatives had clients that had been detained because they were homeless, got into trouble with law enforcement (for example, getting into bar room fights), or behaved in other ways that were seen as socially deviant (for example, sleeping on library couches). While these detainees may have had some mental health problems, the purpose of their detention was not to treat a mental illness.

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29 This is a pattern that was also documented in *Voices of Experience: Thoughts about B.C.'s mental health law from those who have directly experienced it*, by Bill Trott & Peter O'Laughlin, prepared for West Coast Mental Health Network (Vancouver: Community Legal Assistance Society, September 1991) at 4-5. Many survey respondents found when they initiate the process for admission to hospital it was not taken seriously and no one would admit them to hospital, but conversely they were often taken to hospital when they did not want to be admitted.

## Problematic Application of Specific Criteria

Representatives reported observing problematic application of all four criteria across different detainees at different times. To meet the first criterion, physicians must conclude that an individual has a disorder of the mind that requires safe and effective psychiatric treatment and seriously impairs the person's ability to react appropriately to the environment or to associate with others. Several representatives reported experiences with physicians who had concluded that an individual met the first criterion simply by virtue of having a mental health diagnosis, despite the fact that the legislation makes the mere presence of a mental health diagnosis insufficient to meet the first criterion. In relying on an existing diagnosis or focusing on trying to establish a new or different diagnosis, physicians can fail to perform an individualized assessment to evaluate, for example, whether the level of impairment reaches the level of seriousness required for certification.

To meet the second criterion, physicians must conclude whether the individual requires safe and effective psychiatric treatment in or through a designated facility. This criterion is often described as the "treatability" requirement and is interpreted by many to mean that individuals for whom there is no available safe and effective treatment cannot be detained. For example, in Mental Health Law in Canada, the authors discuss the BC *Mental Health Act* criteria and observe that, "[a] requirement of treatability implies that a mental condition for which no known treatment is available cannot serve as the basis for civil committal."<sup>30</sup> However, many advocates and lawyers reported representing clients who have been detained for many years while being administered treatment that has not produced any effect on their symptoms. For example, one representative reported representing an individual who had been detained in an inpatient facility for seven years who was being forcibly administered four high-dose psychotropic pharmaceutical agents simultaneously, although the treating psychiatrist testified it had produced no measurable impact on the mental health symptoms. While some treating physicians candidly admit that the treatments for these individuals have been ineffective, representatives observed that this never seem to result in a conclusion that these individuals do not meet detention criteria. The result is that many individuals are warehoused in facilities for prolonged periods of time while being forcibly administered ineffective psychiatric treatment.

To meet the third criterion, physicians must conclude that the individual requires care, supervision and control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the protection of the person or others. Several representatives pointed out that the concept of substantial deterioration is a broad and relative one that leaves a lot of room for subjective interpretation. As a result, representatives reported a wide variety of inconsistent applications of the substantial deterioration criterion across different detainees. The phrase "substantial mental or physical deterioration" in the civil mental health detention context has been interpreted to mean deterioration that is "considerable, consequential, ample, significant, sizeable."<sup>31</sup> Several representatives expressed concern that physicians often fail to assess whether potential deterioration rises to the level of substantial. Representatives gave examples of physicians pointing to the prospect that an individual may not eat properly, that an individual might smoke cigarettes, or that an individual might use substances, as evidence of potential substantial deterioration.

Finally, to meet the fourth criterion, physicians must conclude that the individual cannot suitably be admitted as a voluntary patient. When asked about problematic applications of specific criteria, representatives

30 Jocelyn Downie, Timothy Caulfield & Colleen M. Flood, *Canadian Health Law and Policy*, 4th ed., LexisNexis Canada Inc., 2011 at 353.

31 *Re C.P.*, 2003 CanLII 15613 (Ont. C.C.B.), referred to with approval in *Thompson and Empowerment Council v. Ontario*, 2013 ONSC 5392 at paras. 116 — 117, aff'd 2016 ONCA 676.

raised more concerns about the voluntariness criterion than any other. Most representatives were of the view that physicians often failed to consider whether there was a way to establish a meaningful voluntary treatment plan with the patient. Representatives described reading in medical records that detainees initially came to hospital voluntarily for treatment, but were certified “in case they changed their minds”. Others reported that they had observed that individuals were automatically certified as if it were a matter of course when they came into hospital voluntarily or were brought in by emergency services, without any assessment of whether the individual would agree to remain in hospital and engage with treatment voluntarily. Representatives reported many examples of representing clients who were discharged after review panels because the treating physician had not explored with the detainees whether they would agree to treatment and could not provide any evidence that the detainee was unsuitable as a voluntary patient.

Representatives also observed that physicians often equate anything short of complete agreement and endorsement with the physician’s diagnoses and treatment plan as making an individual unsuitable as a voluntary patient. One representative described this as a positive obligation on a detainee to agree with the current treating physician’s diagnoses and treatment recommendations in order to be discharged. This can be particularly challenging for patients given that diagnoses and treatment recommendations are often — in the words of one representative — “moving targets”. Representatives reported that it is fairly common to see many different diagnoses from various health care professionals in medical records of individuals with multiple contacts with the mental health system. Similarly, it is common for different health care professionals to recommend a variety of treatment courses over time.

Many representatives reported that nearly all detainees wanted to engage with some form of mental health treatment, but they wanted to have some input into their treatment plans. For instance, representatives had experiences with detainees who were willing to cooperate with any treatment recommendation except Electroconvulsive Therapy or a particular type of psychotropic pharmaceutical agent that had caused them acute side effects. However, representatives observed that any expression of disagreement with the recommended course of treatment could lead to the conclusion that the individual lacks insight into her need for treatment and therefore was unsuitable as a voluntary patient. Representatives gave several examples of clients who had come to hospital voluntarily but had been certified when they responded to a proposed course of treatment by asking to start the psychotropic pharmaceutical agent at a smaller dosage or by asking to try a different agent based on past experiences of what had been effective in treating their mental health symptoms.

Finally, a few representatives raised concerns about health care providers making involuntary status under the *Mental Health Act* a prerequisite for receiving mental health services. For instance, one representative reported an experience with a particular hospital ward refusing admission to someone because he did not have involuntary status. The ward staff explanation was that everyone on the ward had to have involuntary status because if the patient was there voluntarily the staff would have to obtain consent for treatment. As a result, the ward admitted him involuntarily, however, the review panel found that he did not meet the legal criteria for detention shortly after that. Another representative reported an experience with a psychiatrist who refused to provide an individual with a prescription to continue the psychotropic pharmaceutical agent he had been taking while detained after the review panel discontinued his detention, despite the fact that the individual wanted to continue it and was at risk of suffering withdrawal effects with an abrupt discontinuation of the agent. Finally, several representatives reported experiences with mental health teams that refused to continue providing services to patients who wanted to continue with treatment plans following a review panel decision to discontinue detention.



## CONCLUSION AND RECOMMENDATIONS

When physicians examine individuals to decide whether they meet the criteria for detention pursuant to the *Mental Health Act* they are acting as administrative decision makers on behalf of the state. Physicians are responsible for observing procedural fairness and upholding constitutional and statutory rights in applying the legislation to detain an individual. One reason procedural fairness and substantive rights violations are so common in the system for *Mental Health Act* detention may be that physicians have not had sufficient legal training and view themselves only as health care providers, rather than administrative decision makers.<sup>32</sup> As a result, they may see completion of the regulatory forms as a component of medical charting, or as an exercise in bureaucratic ‘paperwork’, rather than a legal decision with constitutional significance.<sup>33</sup>

The provision of the written reasons for detention to detainees in the form of certificates is a fundamental part of ensuring that *Mental Health Act* detention is constitutionally compliant. It is clear from the reports of representatives that most Form 4s and 6s fail to meet the standard set out in judgments like *Abbass* that those Forms must permit others to examine the reasons for detention. At a time when the vast majority of administrative systems function with typed information and forms, it is unclear why any legal document involved in the system for mental health detention should still be completed in hand writing. However, if detaining facilities continue to rely on hand written certificates, they must be filled out legibly, with clear explanations of how the legal criteria for detention apply to the individual in question.

The **Ministries of Health and Mental Health and Addictions should work in conjunction with the health authorities** to create standardized provincial policies and training for physicians who are responsible for making detention decisions pursuant to the *Mental Health Act*. Policies and training must address and correct the existing problems reported above, such as illegible or inadequate reasons for detention and inconsistent or inappropriate application of the detention criteria.

Barriers imposed by health care providers to accessing mental health services as a voluntary patient interferes with the legislative intent of the *Mental Health Act* that patients will not be subject to the rights deprivations of involuntary detention while they are willing to engage voluntarily with health care services. The **Ministries of Health and Mental Health and Addictions should work in conjunction with the health authorities** to take steps to ensure that no health care providers impose a requirement that an individual have involuntary status under the *Mental Health Act* as a prerequisite for receiving mental health care and services.

### SUMMARY OF RECOMMENDATIONS

#### DETENTION DECISIONS

For the Ministries of Health and Mental Health and Addictions in conjunction with the health authorities:

- Create standardized provincial policies and training for physicians making detention decisions to address illegible or inadequate reasons for detention and inconsistent or inappropriate application of the detention criteria.
- Remove requirements for involuntary status under the *Mental Health Act* as a prerequisite for receiving mental health care and services.

32 See for instance, Iva Cheung, *Increasing understanding of the British Columbia Mental Health Act: preliminary work* (September 2016) [unpublished] at 17-20, which documents through interviews with health care providers that physicians misunderstand the legal criteria for certification under the *Mental Health Act*.

33 For an interesting discussion of this topic, see Lora Patton, “These Regulations Aren’t Just Here to Annoy You: The Myth of Statutory Safeguards, Patient Rights and Charter Values in Ontario’s Mental Health System” (2008) 25 Windsor Rev. Legal & Soc. Issues 9.

## QUALIFICATIONS AND PROCEDURES FOR PHYSICIANS MAKING DETENTION AND RENEWAL DECISIONS

The BC *Mental Health Act* has very few safeguards or procedural checks and balances for physicians making detention and renewal decisions. The *Act* authorizes any physician to make detention and renewal decisions through completion of a Form 4 or Form 6. This approach differs from several other Canadian jurisdictions that require at least certain detention decisions be made by psychiatrists. For example, the Manitoba *Mental Health Act* sets out that when a physician is of the opinion that an individual may meet criteria for involuntary admission the physician must apply to the director of a facility for an involuntary psychiatric assessment of the individual.<sup>34</sup> The statute requires that a psychiatrist perform the assessment and file an involuntary admission certificate for the individual.<sup>35</sup> In Nova Scotia, while any physician may complete a certificate for involuntary psychiatric assessment,<sup>36</sup> only a psychiatrist may admit an individual as an involuntary patient by completing and filing a declaration of involuntary admission.<sup>37</sup> Other jurisdictions require at least one of the two physicians completing certificates to be a psychiatrist.<sup>38</sup>

In addition, the BC *Mental Health Act* currently contains no explicit provisions to ensure independence between the two physicians who complete the initial involuntary admission certificates. Prior to 1998, the *Act* disqualified a physician from completing an involuntary admission certificate if the physician was engaged in the practice of medicine in partnership with the physician who completes the other certificate, or a person employed as an assistant by a physician who completed either of the medical certificates in respect of the person whose admission is requested.<sup>39</sup> The requirement for some degree of professional independence between certifying physicians was removed in the 1998 *Mental Health Act* amendments.<sup>40</sup>

Finally, there is longstanding uncertainty with respect to the procedural requirements of physicians in making detention decisions. The BC *Mental Health Act* states that a physician must examine an individual to assess whether she meets the criteria for involuntary admission.<sup>41</sup> While a plain reading of this provision is that a physician must conduct an in-person examination of the individual, there is no statutory definition of what constitutes an examination. The *Guide to the Mental Health Act* produced by the Ministry of Health states that an “examination must include a personal interview with the patient”<sup>42</sup> but notes that there may be an unusual exception where “it would be justifiable for a physician to complete a certificate on the basis of observations of the person and/or listening to the person speak and, if available, information supplied by those who know the person.”<sup>43</sup>

The question of what constitutes an examination has been the subject of confusion and controversy for BC courts. *Mullins v. Levy*<sup>44</sup> raised the question, among other issues, of whether a physician had conducted an examination within the meaning of the *Mental Health Act* after Mr. Mullins refused to speak with her. The BC Supreme Court judge held that a physician who relied on the decision of the first certifying physician

34 *Mental Health Act*, C.C.S.M. c. M110, s. 8.

35 *Ibid*, ss. 16-18.

36 *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42, s. 8.

37 *Ibid*, s. 17.

38 *Alberta Mental Health Act*, s. 8(2); *The Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1, s. 24(3).

39 *Mental Health Act* as it appeared on December 31, 1997, s. 22(3).

40 *Mental Health Amendment Act*.

41 *Mental Health Act*, s. 22.

42 *Guide to the Mental Health Act* at 80.

43 *Ibid* at 11.

44 *Mullins v. Levy*, 2005 BCSC 1217

without conducting an in-person examination of a patient before completing the second Form 4 had “completely abrogated her duty under the Act”.<sup>45</sup> The BC Court of Appeal disagreed with this finding, and instead held that an examination

*must mean observing the person, reviewing the patient’s chart (if there is one), reviewing the available history and collateral information, and where possible (in the sense that the person complies) and necessary (in the sense that the information to be gained is not available from other sources) conducting a personal interview with the person to be admitted. No one suggests that the physician’s examination be treated other than with utmost seriousness. The decision to certify obviously has profound implications for the liberty of persons who may be held against their will for significant periods of time.*<sup>46</sup>

## REPRESENTATIVES REPORTED

Representatives reported that you often cannot tell from the Form 4 or Form 6 whether the certifying physician conducted an in-person examination.

When asked about the distinctions between psychiatrists and physicians without psychiatric specialization who make detention decisions pursuant to the *Mental Health Act*, representatives reported that they usually had no way of knowing whether the decision maker completing the Form 4s or Form 6s was a psychiatrist or a physician without psychiatric specialization. The Form 4 and Form 6 require that physicians document their name, address, and signature, but not their title or qualification. There is therefore no way of tracking from the certificates how often physicians without psychiatric specialization make detention decisions.

There is similarly no requirement on the Form 4 or Form 6 that the certifying physician document whether she conducted an in-person examination of the patient in making the detention decision. Representatives reported that you often cannot tell from the Form 4 or Form 6 whether the certifying physician conducted an in-person examination. For example, many representatives reported encountering records in which the two Form 4s have identical wording or the second Form 4 imitates the language of the first Form 4 with only one or two distinguishing words, which may indicate that the second physician simply relied on a chart review and copied the first physician’s decision documented on the Form 4, rather than conducting an independent examination of the detainee.

However, several representatives had represented clients who were subject to detention decisions without an in-person examination. For example, several representatives reported encountering circumstances where at least one of the physicians who completed the Form 4 documented in records that he did not examine the patient in person, but rather, relied on a review of the chart or a conversation with the initial certifying physician. Representatives also reported that some certificates make it clear that the detention decision was completed without an in-person examination. For example, initial detention decisions can rely heavily on collateral information conveyed by third parties or information from the patient’s history.

<sup>45</sup> *Ibid* at para. 90.

<sup>46</sup> *Mullins v. Levy*, 2009 BCCA 6 at paras. 106-107.

Several representatives pointed out that the information provided by third parties can be unreliable, exaggerated, or otherwise inaccurate. One representative explained that once an initial detention decision is made, the focus switches to administering psychiatric treatment, rather than engaging in further information gathering and assessment, which underscores the importance of the initial assessments.

## CONCLUSION AND RECOMMENDATIONS

As with so many components of the administrative system for mental health detention in BC, there is inadequate information on current practices to analyze what would constitute best practices. Without establishing or documenting the qualifications and procedures for physicians making detention and renewal decisions, the system lacks the transparency necessary to evaluate the efficacies of current safeguards. A basic first step, then, must be to begin tracking this information.

Detention decisions are extraordinary state intrusions into individual liberty and security of the person and must be carried out conscientiously, with fair procedures. Given the seriousness of these decisions and the significant lack of safeguards once an individual is detained, detention decisions should be made with all available information and the most reliable information. In-person assessment is a fundamental component of an examination and a critical safeguard to ensure that physicians exercise independent judgment in making detention decisions, rather than collapsing the legislative requirement for two independent examinations into one examination and an echo of that examination.

The **BC Government** should review and amend the *Mental Health Act* to create a clear definition of examination that includes the requirement for an in-person assessment for the purpose of making a detention decision. If there are exceptional circumstances in which a detention decision may be made without an in-person assessment, there must be clear criteria defining such circumstances and establishing a requirement to conduct an in-person assessment as soon as possible. Any detention decision should include documentation of the name and qualification of the certifying physician and an indication of whether the certifying physician conducted an in-person assessment when completing the examination.

Regardless of legislative reform, the **Ministries of Health and Mental Health and Addictions should work in conjunction with the health authorities** to create standardized provincial policies and training regarding best practices for conducting an examination for the purposes of making detention decisions, which includes in-person assessments.

## SUMMARY OF RECOMMENDATIONS

### DETENTION PROCEDURES

For the BC Government:

- Review and amend the *Mental Health Act* definition of “examination” for the purposes of detention, including in-person assessments.

For the Ministries of Health and Mental Health and Addictions in conjunction with the health authorities:

- Create standardized provincial policies and training regarding best practices for detention examinations, including in-person assessments.

## DISCHARGE OF DETAINEES WHO NO LONGER MEET DETENTION CRITERIA

Once detained under the *Mental Health Act*, individuals can be discharged at any time by the director through completion of a Form 19—Certificate of Discharge. In practice, discharge decisions are made by a detainee's treating physician. Detainees may only be maintained with involuntary status while they continue to meet the legal criteria for detention. Involuntary admission decisions often rely on collateral reports from third parties, like friends, family members, and service providers, and initial examinations of the detainee who may be in crisis or under the influence of substances at the time. After admission, treating physicians are responsible for engaging in ongoing evaluation of detainees and gathering further information from third parties. Treating physicians must discharge detainees when they no longer meet the criteria for detention.

### REPRESENTATIVES REPORTED

Representatives reported that it was often challenging to assess whether physicians were appropriately discharging detainees who no longer met criteria for detention. As with decisions to involuntarily admit detainees pursuant to the *Mental Health Act*, representatives have observed a great deal of variety in how physicians engage in ongoing assessments to make discharge decisions. One representative reported that it seems that some physicians will never discharge a patient even when it appears obvious that they should and a review panel takes very little time in deliberation to find that the patient does not meet the criteria, whereas other physicians will discharge a patient who may still meet the criteria because they do not want to go through the work involved in presenting the case for detention at a review panel hearing. Several representatives were concerned that physicians had insufficient training on the legal criteria for detention and their role and responsibility as administrative decision makers in making detention and discharge decisions.

*"There's been a few times when I have been cross-examining doctors about the criteria and they don't know what the criteria is... I've asked them well what criteria did you apply in continuing this person's detention and they have the forms in front of them and they don't, they can't name them... That's good for the hearing, but obviously not as a general practice."*

Many representatives reported that it was common for treating physicians to discharge patients immediately before a scheduled review panel hearing. Representatives explained that there could be many different reasons for this trend. It could simply be that physicians are appropriately discharging detainees who no longer met the criteria and the timing of the upcoming hearing is coincidental. However, several representatives theorized that physicians may realize in preparing to present the case for detention that the patient had already ceased meeting the criteria some time ago and would likely be discharged at the upcoming review panel. Others were of the view that treating physicians may seek to detain patients who no longer met criteria for as long as possible because they considered the hospital to be a better environment for their patients. For example, some treating physicians tell their patients or document in medical records that they will discharge patients at a specific point in time in the future, or that they will let the certificate for detention lapse at the end of the current certification period without renewing detention. Representatives pointed out that these practices did not comport with the statutory scheme of the *Mental Health Act*—if a detainee no longer meets criteria they must be discharged immediately, there is no basis for maintaining involuntary status for someone who no longer meets criteria.

## IN THE WORDS OF THE LEGAL REPRESENTATIVES:

“There’s been a few times when I have been cross-examining doctors about the criteria and they don’t know what the criteria is... I’ve asked them well what criteria did you apply in continuing this person’s detention and they have the forms in front of them and they don’t, they can’t name them... That’s good for the hearing, but obviously not as a general practice.”

Several representatives reported that some physicians offer to place inpatient detainees on extended leave in exchange for the detainee cancelling an upcoming review panel, as a way to ensure forced psychiatric treatment will continue when there was the potential the review panel would find the detainee did not meet legal criteria. The practice of some health care providers in offering inducements, making threats, exerting pressure, and actively interfering with detainees’ right to a review panel will be discussed in more detail in section 5 | [Scheduling and Preparing for a Review Panel](#).

Many representatives expressed concern that detainees placed on extended leave in the community were more likely than inpatient detainees to be kept with involuntary status when they no longer met criteria. Lawyers and advocates reported representing detainees who had been maintained with involuntary status on extended leave for several years — sometimes as long as 10 years. Representatives explained that detainees on extended leave often went prolonged periods of time without being examined by their treating psychiatrist. For example, one lawyer reported that she had represented a detainee on extended leave who had not met with the treating psychiatrist in eight months. While the detainee had met with other members of the mental health team during that time, the treating psychiatrist made detention renewal decisions without examining the detainee to evaluate whether the criteria were still met.

Finally, some representatives reported that there appeared to be a class bias in how long individuals were detained. These representatives reported that affluent people were more likely to be released because they had access to safe housing and appropriate supports. In contrast, poorer detainees were more likely to be kept in prolonged detention, not because they required mental health treatment, but because they did not necessarily have access to safe housing and adequate supports. In a similar vein, several representatives raised concerns about a small subset of detainees they had encountered who appeared to have “fallen through the cracks” and been detained and subject to involuntary psychiatric treatment for prolonged periods of time with no apparent plan to facilitate their return to community or transfer them to a less restrictive setting. They commented that it was unclear whether these detainees were being kept in prolonged detention because their mental disorder was not improving with treatment, there was no available housing for them, or there was simply no one in a position to monitor the need for, or conditions of, their ongoing detention.



## SUMMARY OF RECOMMENDATIONS

### DISCHARGE DECISIONS

For the Ministries of Health and Mental Health and Addictions in conjunction with the health authorities:

- Create standardized provincial policies and training for physicians responsible for detention decisions to address current problems, such as the failure to discharge detainees who no longer meet the legal criteria for detention.

## CONCLUSION AND RECOMMENDATIONS

Representative reports make it clear that there is a great deal of variety in treating physicians' discharge practices and that at least some detainees remain in detention longer than legally permitted by the *Mental Health Act*. Detention and the rights deprivations that flow from involuntary status under the *Mental Health Act* are significant incursions into an individual's life that may only be maintained as long as the detention criteria are met. Part of the challenge in assessing whether detainees are being appropriately discharged when they no longer meet the legal criteria for detention is the lack of tracking and evaluation of ongoing detention. The Ministry of Health does not engage in sufficient monitoring of the length of *Mental Health Act* detention periods, which would enable systemic oversight, such as comparisons among average detention lengths among facilities, mental health teams, and health authorities. The reports of detainees in prolonged detention with no apparent plan to facilitate their return to community or their transfer to a less restrictive setting highlights the need for improved oversight from those responsible for the mental health detention system. Insufficient oversight and data tracking will be discussed in more detail in section 7 | [Oversight and Accountability](#).

The **Ministries of Health and Mental Health and Addictions should work in conjunction with the health authorities** to create standardized provincial policies and training for physicians who are responsible for making detention decisions pursuant to the *Mental Health Act*. Policies and training must address and correct the current problems reported above, such as the failure to discharge detainees who no longer meet the legal criteria for detention.

# 2 | Restraints and Seclusion

## OVERVIEW

**MENTAL HEALTH ACT DETAINEES** who are held in a facility can be subject to physical, mechanical, environmental, and chemical restraints. The use of restraints and seclusion is a significant and often traumatic incursion on a detainee's freedom and personal security. It is therefore critical that the use of restraints and seclusion is carefully governed, documented, monitored, and subject to review. However, one of the fundamental challenges in analyzing restraint and seclusion use in BC is that we have no shared definition of what constitutes restraint or seclusion. The *Mental Health Act* has no definition of restraints or seclusion and no criteria governing what form of restraints and seclusion can be used, under what circumstances, and for what period of time. The statute grants sweeping powers to the director and the facility staff to direct and discipline detainees:

### **Direction and discipline of patients**

**32** Every patient detained under this Act is, during detention, subject to the direction and discipline of the director and the members of the staff of the designated facility authorized for that purpose by the director.

For detainees in facilities, this means that they can be put in seclusion (solitary confinement in a small, locked room), tied to a bed with 4-point or 5-point mechanical restraints (one strap is used for each limb and sometimes to additionally restrain the head), restricted to certain rooms or wards with locked doors, subject to physical force by health care providers and private security guards, denied their own clothes, and have their clothes forcibly removed. Detainees can also be subject to chemical restraints—psychotropic pharmaceutical agents which are administered to control behaviour rather than to provide therapeutic benefits. There is no legal requirement to document the use of restraints or seclusion. There is no administrative body to oversee the use of restraints and seclusion that detainees can complain to when they are subjected to restraint or seclusion.

Security services can be provided through various arrangements in designated facilities throughout BC. Some facilities hire and train their own security guards, whereas others contract with one of a number of private companies to provide security services. The

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diversity of these arrangements in the Lower Mainland has reduced in recent years with the establishment of the Lower Mainland Integrated Protection Services. The Integrated Protection Services consolidated the provision of security services for the Fraser Health Authority, the Vancouver Coastal Health Authority, Providence Health Care, and the Provincial Health Services Authority.<sup>1</sup> The Integrated Protection Services has contracted with the company Paladin Security for security services in designated facilities throughout Metro Vancouver, the Fraser Valley, and the Sunshine Coast regions.

This section will begin with a discussion on the absence of legal criteria governing the use of restraints and seclusion with detainees. The section will consider what this means in practice, both in terms of the level of documentation of restraints and seclusion use and the reasons for restraint and seclusion use. The section will then turn to the issue of clothing and clothing removal for detainees, again a topic on which there is no governing legal criteria. The section will conclude by considering some of the issues this presents for detainees, including detainees being forced to participate in legal proceedings in hospital gowns/pyjamas and female detainees having their clothes forcibly removed by male facility staff and male private security guards.

## NO LEGAL CRITERIA GOVERNING RESTRAINTS AND SECLUSION

There are no criteria in the *BC Mental Health Act* or *Mental Health Regulation* that define, govern, or establish oversight of restraints and seclusion use against detainees. This absence is particularly concerning in light of the fact that regardless of why they are used, restraints and seclusion can cause harm to individuals and create or contribute to mental health problems. The Ministry of Health's provincial guidelines, *Provincial Quality, Health and Safety Standards and Guidelines for Secure Rooms in Designated Mental Health Facilities under the B.C. Mental Health Act*, state:

*There is no evidence that seclusion contributes to healing or recovery, and there is strong support for the claim that it can be harmful to the individual being secluded as well as to those who witness or deliver the intervention... Some experts have argued that seclusion is not a treatment at all, but a treatment failure.<sup>2</sup>*

On August 7, 2016 the College of Family Physicians of Canada released a position statement in support of abolishing the use of solitary confinement in Canadian correctional institutions, which states:

*The United Nations (UN) considers any stay in solitary confinement over 15 days as torture, but the negative consequences of sensory deprivation can be seen as early as 48 hours after segregation. These include onset of mental illness, exacerbation of pre-existing mental illness, and the development or worsening of physical symptoms.*

...

*4. Solitary confinement for mental illness (including those with post-traumatic stress disorder) is inappropriate. These persons require care in a specialized setting that will address the mental health needs rather than exacerbate them in solitary confinement.*

1 Providence Health Care, "Lower Mainland Integrated Protection Services" (13 October 2011), online: <<http://www.providencehealthcare.org/careers/postings/lower-mainland-integrated-protection-services>>.

2 British Columbia Ministry of Health, "Provincial Quality, Health and Safety Standards and Guidelines for Secure Rooms in Designated Mental Health Facilities under the B.C. Mental Health Act (June 2014), online: <<https://www.interiorhealth.ca/AboutUs/BusinessCentre/Construction/Documents/Provincial%20standards%20and%20guidelines%20for%20secure%20rooms.pdf>> [*Guidelines for Secure Rooms in Designated Mental Health Facilities*] at 25.

5. *Solitary confinement for discipline is not recommended. The evidence shows that it is not effective and that better options exist. [citations omitted]*<sup>3</sup>

The use of restraints and seclusion against *Mental Health Act* detainees infringes several rights guaranteed by the *Charter*. For example, s. 7 protects the right to life, liberty, and security of the person, which is impacted by restrictions on detainees' freedom of movement within facilities, non-consensual physical touching and forced administration of psychotropic pharmaceutical agents. Section 9 guarantees the right to be free from arbitrary detention, which requires that clear criteria be established to govern the circumstances in which restraints and seclusion can be imposed. In certain circumstances, restraints or seclusion can amount to a violation of the s. 12 right to be free from cruel and unusual treatment or punishment, particularly if they are imposed as a disciplinary measure.

At the time this report is being written, there is a pending *Charter* challenge to the use of solitary confinement in prison, *British Columbia Civil Liberties Association and The John Howard Society of Canada v. Attorney General of Canada*.<sup>4</sup> The claim alleges that the use of solitary confinement amounts to cruel and unusual punishment by, among other things, creating mental health problems or exacerbating existing ones. Notably for the purposes of this report, the claimants argue that the administrative review process available for prisoners to challenge their solitary confinement is inadequate to provide effective and independent oversight. For *Mental Health Act* detainees, there is no recourse whatsoever to challenge their seclusion.

The BC Government has long been aware that the absence of legal criteria governing restraints is a troubling vacuum for *Mental Health Act* detainees. In 1994, the Ombudsperson called on the BC Government to review and amend the law governing restraints in *Listening: A Review of Riverview Hospital*.<sup>5</sup> The *Listening* report identified the following problems with restraint and seclusion use:

- the BC *Mental Health Act* did not clearly prohibit the use of restraints against voluntary patients;
- the BC *Mental Health Act* had no definition of restraint;
- the BC *Mental Health Act* lacked the safeguard of a "minimal use" standard;
- restraint use did not require a representative or substitute decision maker to consent to the restraint;
- there was no requirement to document the use of restraints;
- access to the hospital grounds and the community were inappropriately treated as "privileges", which made it "seem that freedom of movement is a privilege, rather than a right that is denied to some patients some of the time on the basis of their mental condition."
- the use of restraints and seclusion was not subject to review by review panels or any other administrative tribunal; and
- detainees were sometimes put in seclusion not to prevent harm, but with the intention of modifying behaviour, even though "major mental illness is not primarily a behavioral issue", or

3 The College of Family Physicians in Canada, "Position Statement on Solitary Confinement" (7 August 2016), online: <[http://www.cfpc.ca/uploadedFiles/Directories/Committees\\_List/Solitary%20Confinement\\_EN\\_Prison%20Health.pdf](http://www.cfpc.ca/uploadedFiles/Directories/Committees_List/Solitary%20Confinement_EN_Prison%20Health.pdf)>.

4 Notice of Civil Claim, Vancouver Registry, No. S-167325 (B.C.S.C.).

5 British Columbia, Office of the Ombudsperson, *Listening: A Review of Riverview Hospital*, Public Report No. 33 (May 1994), online: <<https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2033%20Listening%20A%20review%20of%20Riverview%20Hospital.pdf>> [*Listening*].

the intention of creating a therapeutic benefit, when in fact “placing an individual with mental illness in isolation, cut off from human contact, and with limited sensory stimulation, can have negative consequences”<sup>6</sup>

In the 1991 report *Voices of Experience: Thoughts about B.C.’s mental health law from those who have directly experienced it*, the researchers found that the use of seclusion elicited the strongest survey responses from people who have experienced *Mental Health Act* detention.<sup>7</sup> Survey respondents observed that seclusion was often used as a punishment or to ease the workload of staff, rather than for any therapeutic reason.<sup>8</sup> The survey respondents reported feelings of desperation, helplessness, abandonment, humiliation, and claustrophobia when put in seclusion.<sup>9</sup> They recommended that seclusion use should be limited to situations where it was necessary to prevent violence or disturbance to other patients and should be governed by strict guidelines in order to prevent harm to the detainees.<sup>10</sup> Several respondents who had experienced detention in jail and under the *Mental Health Act* expressed that they had fewer rights as an involuntary patient than as prisoners and they would prefer to be in jail than detained in a psychiatric facility.<sup>11</sup>

In *Growing the Problem, The Second Annual Report of the Mental Health Advocate of British Columbia*, January 1 — December 31, 2000, the Mental Health Advocate documented calls to her office from individuals who were reluctant to seek health care services because of traumatic events they or a loved one had experienced in mental health facilities.<sup>12</sup> The Mental Health Advocate expressed particular concern about the lack of monitoring of isolation and restraint use and recounted the experiences of a 19 year old man who had been kept in seclusion for 5 weeks and a woman who was restrained by security guards every time she had to go to the bathroom.<sup>13</sup>

In the 2012 report, *The Best of Care: Getting it Right for Seniors in British Columbia*,<sup>14</sup> the Ombudsperson discussed restraint use with seniors in residential care facilities:

*Regardless of the circumstances or the method used, restraining someone reduces that person’s individual liberty and affects his or her dignity. Given the gravity of this consequence, it is vital that all types of restraints be used to the least degree necessary. Restraints should only be used to protect the health and safety of the person being restrained, other residents and employees. They cannot be used to discipline or coerce residents, or for the convenience of facility staff.*<sup>15</sup>

*The Best of Care* report went on to point out that there were inconsistent criteria governing restraint use for seniors in residential care facility settings. While some residential care facility settings were governed by clear criteria in the *Residential Care Regulation*<sup>16</sup> pursuant to the *Community Care and Assisted Living Act*,<sup>17</sup> the use of restraints in residential care facilities governed by the *Hospital Act* were subject to fewer

6 *Ibid* at 5-21 to 5-38.

7 *Voices of Experience: Thoughts about B.C.’s mental health law from those who have directly experienced it*, by Bill Trott & Peter O’Laughlin, prepared for West Coast Mental Health Network (Vancouver: Community Legal Assistance Society, September 1991) at 16.

8 *Ibid* at 17.

9 *Ibid*.

10 *Ibid* at 18-19.

11 *Ibid* at 21.

12 *Growing the Problem: The Second Annual Report of the Mental Health Advocate of British Columbia January 1 — December 31, 2000* (Victoria: the Mental Health Advocate of British Columbia).

13 *Ibid* at 41.

14 British Columbia, Office of the Ombudsperson, *The Best of Care: Getting it Right for Seniors in British Columbia*, Part 2, Public Report No. 47 (February 2012), online: <<https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2047%20The%20Best%20of%20Care-%20Getting%20it%20Right%20for%20Seniors%20in%20BC%20%28Part%20%29%20Overview.pdf>>.

15 *Ibid* at 101.

16 B.C. Reg. 96/2009 [*Residential Care Regulation*].

17 S.B.C. 2002, c. 75.

**There are no criteria in the BC *Mental Health Act* or *Mental Health Regulation* that define, govern, or establish oversight of restraints and seclusion use against detainees. This absence is particularly concerning in light of the fact that regardless of why they are used, restraints and seclusion can cause harm to individuals and create or contribute to mental health problems.**

regulatory safeguards. The Ombudsperson recommended that the Ministry of Health take the necessary steps to ensure that the use of restraint in all residential care facilities was governed by the *Community Care and Assisted Living Act*'s standards for the use of restraints.

It is instructive to consider the BC criteria governing restraints in the *Residential Care Regulation* pursuant to the *Community Care and Assisted Living Act*. These criteria create minimum legal standards that must be followed when restraints are used against residents of residential care facilities, many of whom have mental disabilities. It is unclear why the BC Government has chosen to enact such careful legal criteria for some populations in facilities, while severely neglecting the criteria for another population. To add to the confusion, some *Mental Health Act* detainees can be placed involuntarily in a residential care facility pursuant to the extended leave provisions of the statute.<sup>18</sup> The facility the detainee is placed in may be required to follow the legal standards established in the *Residential Care Regulation*, which creates even further inconsistencies in the law governing the use of restraints for *Mental Health Act* detainees.

The *Residential Care Regulation* establishes comprehensive criteria governing the use of restraints. The regulations define "restraint" as "any chemical, electronic, mechanical, physical or other means of controlling or restricting a person in care's freedom of movement in a community care facility, including accommodating the person in care in a secure unit".<sup>19</sup> Restraints must not be used unless:

- (a) the restraint is necessary to protect the person in care or others from serious physical harm,
- (b) the restraint is as minimal as possible, taking into consideration both the nature of the restraint and the duration for which it is used, and
- (c) the safety and physical and emotional dignity of the person in care is monitored throughout the use of the restraint, and assessed after the use of the restraint.<sup>20</sup>

The *Residential Care Regulation* sets out that restraints may be used when "the restraint is necessary to protect the person in care or others from imminent serious physical harm".<sup>21</sup> All alternatives to the use of the restraint must first have been considered and either implemented or rejected and the employees administering the restraint must have received training on the use of such alternatives.<sup>22</sup> The use of the restraint, its type, and the duration for which it is used must be documented.<sup>23</sup> Restraints must never be used for the purpose of punishment or discipline, or for the convenience of employees.<sup>24</sup> If a restraint is

<sup>18</sup> R.S.B.C. 1996, c. 288, ss. 37-38.

<sup>19</sup> *Residential Care Regulation*, s. 1.

<sup>20</sup> *Ibid*, s. 73(1).

<sup>21</sup> *Ibid*, s. 74(1)(a).

<sup>22</sup> *Ibid*, s. 73(2) (a)-(b).

<sup>23</sup> *Ibid*, s. 73(2)(c).

<sup>24</sup> *Ibid*, s. 74(2).



implemented, the facility must reassess the need for the restraint at least once within 24 hours after the first use of the restraint.<sup>25</sup> If the restraint continues for more than 24 hours there is a process set out for obtaining consent and engaging in reassessment of the ongoing restraint.<sup>26</sup>

Unlike BC, other Canadian jurisdictions have established legal criteria governing the use of restraints with individuals in mental health detention. For example, the Ontario *Mental Health Act*<sup>27</sup> defines restraint and creates the following criteria:

- s. 1** ... “restrain” means place under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient;
- s. 14** Nothing in this Act authorizes a psychiatric facility to detain or to restrain an informal or voluntary patient.
- s. 53. (1)** The use of restraint on a patient shall be clearly documented in the patient’s record of personal health information by the entry of a statement that the patient was restrained, a description of the means of restraint and a description of the behaviour of the patient that required that the patient be restrained or continue to be restrained.
- (2)** Where a chemical restraint is used, the entry shall include a statement of the chemical employed, the method of administration and the dosage.

The Manitoba *Mental Health Act*<sup>28</sup> similarly defines “restrain” and creates the following criteria:

- s. 1** ... “restrain”, with respect to a patient, means to place under control when necessary to prevent harm to the patient or to another person by the minimal use of such force, mechanical means or medication as is reasonable having regard to the patient’s physical and mental condition;
- s. 29(3)** Psychiatric treatment may be given under this section by the use of such force, mechanical means or medication as is reasonable having regard to the patient’s physical and mental condition.
- s. 29(4)** Measures taken under subsection (2) to treat or restrain a patient without his or her consent must be recorded in detail in the patient’s clinical record, and must include the following:
  - (a) where medication is used, an entry of the medication used that includes the dosage and the method and frequency of administration; and
  - (b) where force or mechanical means are used to restrain the patient, a statement that the patient was restrained that includes
    - (i) a description of the means of restraint,
    - (ii) a statement of the period of time during which the patient was or is expected to be restrained, and
    - (iii) a description of the behaviour that required the patient to be restrained or continue to be restrained.

<sup>25</sup> *Ibid*, s. 75(1).

<sup>26</sup> *Ibid*, s. 75(2)-(3).

<sup>27</sup> R.S.O. 1990, c. M-7, ss. 1, 14, 53.

<sup>28</sup> C.C.S.M. c. M110, ss. 1, 29(3), 29(4).

It has been argued that the absence of criteria governing restraint use is also a violation of Article 15 the UN CRPD, which prohibits torture and cruel, inhuman or degrading treatment or punishment. In *Equality, Dignity and Inclusion: An Evaluation of British Columbia's Mental Health Laws, Policies and Service Standards*, Beverly Froese states that in the context of mental health detention, this right is respected when the use of practices such as a restraint and seclusion are regulated and alternative practices are developed and promoted.<sup>29</sup> Froese found that the BC *Mental Health Act* did not address any of the basic requirements for regulating restraint use because the statute failed to:

- expressly define the terms “seclusion” and “restraint”;
- prohibit their use as a means of punishment;
- confirm their use is to be avoided to the greatest extent possible, for example by restricting their use to circumstances when it is the only means available to prevent immediate harm to the person or others and it is not prolonged beyond the time period for which it is necessary;
- require their use to be supervised by staff and documented by staff;
- require the person’s personal representative and/or support network to be advised if they are used, unless the person’s wishes are otherwise; and
- promote the use of alternative practices.<sup>30</sup>

## REPRESENTATIVES REPORTED

### Documentation of Restraints and Seclusion Use

Representatives identified that there was a lack of clear law governing the use of restraints and seclusion. Although some health authorities, facilities, and wards have developed policies regarding restraint and seclusion use, these vary widely across the province, are not necessarily available for review by the public, and are not legally binding. Representatives reported that it was often challenging and pointless to try to review the use of restraints and seclusion and raise questions with the facility staff in the absence of legal criteria against which to measure the restraints and seclusion used with their clients.

Although most representatives reported that when restraint or seclusion was used there was usually a note of it on the detainee’s medical records, several said that they had seen situations in which a restraint was used and had not been documented on their client’s medical records. When restraints were documented, the documentation was not always consistent and it was rarely described with any detail. For instance, representatives said they often see a one-sentence note in a client’s records that 4-point mechanical restraints were used to tie each of a patient’s limbs to a bed, but not what behaviour precipitated the use of restraints, what efforts were made to provide care to the patient before restraints were resorted to, or what period of time the restraints were used for.

When discussing the documentation of restraints and seclusion on their client’s medical records, representatives used phrases like “it’s a detective job”, “it’s not always clear, but you can hunt for it”, you have to “dig through nursing notes to find out”, “you can usually guess”, or you can “sleuth to figure it out”.

<sup>29</sup> British Columbia, *Equality, Dignity and Inclusion: An Evaluation of British Columbia's Mental Health Laws, Policies and Service Standards*, by Beverly Froese, in Report to the Law Foundation of British Columbia (Victoria: 31 March 2017), at 89.

<sup>30</sup> *Ibid* at 91.

For example, representatives reported that in some facilities there is a practice to record seclusion on a separate document, which tracked both the time that someone entered and exited seclusion, as well as periodic checks on the individual at certain intervals. However, in other facilities the documentation was much less clear, for instance, there would be a note in the records that someone was put in seclusion at a certain time, but no documentation about when that person exited seclusion, it would simply be apparent that at some point in time the person was let out of seclusion because there would be a note that he was back in his room or in the common room. Some representatives said that they have seen seclusion use which was not recorded at all in the patient's chart, but there was a reference to seclusion use after the fact in a physician's report to the review panel.

### Reasons for Restraint and Seclusion Use

Given the absence of clear and consistent documentation, it is not surprising that when asked about the reasons restraints and seclusion were used with their clients, the most common response from representatives was that the level of documentation was usually insufficient to be able to effectively know why restraints or seclusion were used. Clear documentation of restraints and seclusion is a necessary precursor to enabling meaningful review of their use. As discussed, the standard established in other BC regulations, Canadian mental health statutes, and the UN CRPD is that restraints and seclusion must only be used as a last resort when it is the only means available to prevent imminent physical harm to the person or others. The Ministry of Health's *Guidelines for Secure Rooms in Designated Mental Health Facilities* state that seclusion is a "short-term emergency measure of last resort, used only when all efforts to prevent the use of seclusion have failed."<sup>31</sup> The guidelines further state that seclusion "must only be used to prevent patients from harming themselves or others" and that it must "never be used as a disciplinary or punitive measure."<sup>32</sup>

It was clear from the interviews that restraints and seclusion are frequently used for reasons other than preventing harm. According to representatives, restraints and seclusion, and the threat of imposing them, were most commonly used for two reasons. First, many examples were reported of restraints and seclusion, or their threat, being used as a disciplinary measure, a behaviour modification tactic, or for staff convenience. For instance, representatives identified the following examples of seclusion uses:

- Detainees were put in seclusion for being argumentative or not doing what they were told to do by staff. One representative described that restraints and seclusion were often used to "show who's the boss." Another representative reported an example of a woman being put in seclusion for being out of bed when she was not allowed to be because she was using a relaxation technique to help her sleep.
- Detainees were put in seclusion when they were irritable or causing a disruption, for example, by yelling. One representative recounted an example of a detainee being put in seclusion who was very upset by something disturbing that was playing on the television in the common room and was repeatedly asking for the channel to be changed.
- Detainees were put in seclusion when they were being a nuisance to the staff, for example, by approaching the nurses' station frequently to talk to them.

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<sup>31</sup> *Guidelines for Secure Rooms in Designated Mental Health Facilities* at 27.

<sup>32</sup> *Ibid* at 28.

- Detainees were told that they would lose privileges if they did not cooperate or had privileges revoked for not cooperating, such as access to clothes or the internet. For example, some representatives reported seeing notes in the medical records that a detainee's outdoor grounds passes to go for a walk were rescinded as a disciplinary measure.
- Detainees were put in 4-point restraints or put in seclusion as a standard admission practice in some wards, regardless of whether it was required in the specific situation.

The second most common reason representatives saw restraints and seclusion, or the threat of them, used was to facilitate forced administration of treatment the detainee did not consent to. One representative explained seeing notes in medical records to the effect of: 'patient did not want to take pill, so I told him that if he didn't we would call security, put him in seclusion, and inject him'. Forced injections can involve a great deal of physical force and once detainees have had the experience of being pinned face down to their beds by private security guards with their pants and underwear removed and a needle injected into their gluteus, they often capitulate to taking pills when faced with the threat of such force again. Some representatives reported that they have seen detainees put in seclusion for failing to cooperate with treatment and told that they would not be let out of seclusion until they agreed to treatment. Forced administration of treatment can also overlap with a disciplinary measure, staff convenience, or behaviour modification tactic. For example, some representatives said that it is common for detainees to become upset and agitated when faced with forced administration of pharmaceutical agents and try to express opposition to the treatment.

As discussed in section 4 | [Psychiatric Treatment](#), physicians sometimes record restraints and seclusion as a treatment method on Form 5s. One representative reported that at a review panel hearing her client's treating psychiatrist testified that the client had been kept in seclusion for several days for therapeutic reasons. This practice is alarming given the overwhelming evidence that there is no therapeutic value to seclusion and that the sensory deprivation and lack of human contact have demonstrated and significant harms to an individual's mental health.<sup>33</sup>

The use of chemical restraints was an issue of concern raised by many representatives. Again, one of the most pressing challenges in considering chemical restraints is that it is difficult to tell from medical records whether a psychotropic pharmaceutical agent was being used with the intention to chemically restrain a detainee or to provide a therapeutic benefit to a detainee. In some cases, it was clear from the records that pharmaceutical agents were administered to sedate detainees and make their behaviour easier for staff to control and modify. However, many representatives said that they often could not tell from looking at their client's records whether a pharmaceutical agent was being used for behaviour management purposes. For example, one representative recounted that he had seen medical records classifying a particular pharmaceutical agent as a chemical restraint being administered to sedate a client at one point and then later in the records the same pharmaceutical agent was recorded as a mood stabilizer being administered for treatment purposes. Without any legal requirement to document chemical restraints, a pharmaceutical agent can simply form part of a detainee's treatment regime without clarification of the purposes for which it is being prescribed.

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<sup>33</sup> *Ibid* at 25.

## SUMMARY OF RECOMMENDATIONS

### RESTRAINTS AND SECLUSION

For the BC Government:

- **Review and amend the *Mental Health Act* to create legal criteria that governs the use of restraints and seclusion with detainees.**

For the Ministries of Health and Mental Health and Addictions in conjunction with the health authorities:

- **Expand and update standardized provincial policies and training regarding the use of restraints and seclusion to address current problems, such as seclusion use as a disciplinary measure or for staff convenience.**

## CONCLUSION AND RECOMMENDATIONS

BC has fallen far behind other Canadian jurisdictions in governing the use of restraints and seclusion against detainees. Not only does the *Mental Health Act* fail to prohibit the use of restraints and seclusion as a disciplinary measure, our legislation actively authorizes the discipline of detainees. The *Mental Health Act*'s failure to define and regulate the use of restraints and seclusion does not fulfill the rights guaranteed by the *Charter* and international human rights embedded in the requirements of the UN CRPD. The result is that detainees are subject to many different forms of restraints that impede their freedom of movement without adequate justification, documentation, or independent oversight. Although the Ministry of Health has attempted to standardize provincial policy in *Guidelines for Secure Rooms in Designated Mental Health Facilities*, these guidelines do not adequately address other forms of restraint and, as a non-binding policy without the force of law, it is often ignored in practice.

The **BC Government** should review and amend the *Mental Health Act* to create legal criteria that governs the use of restraints and seclusion with detainees. The BC criteria governing restraints in the *Residential Care Regulation* pursuant to the *Community Care and Assisted Living Act* serve as a good example on which to model restraint criteria in the *Mental Health Act*. Amendments must, as a minimum, address the following:

- 1) A definition of restraints and seclusion, which includes mechanical, environmental, physical, and chemical restraints;
- 2) A prohibition on using restraints and seclusion as a disciplinary measure, for staff convenience, or as a treatment method;
- 3) A requirement that restraints and seclusion are only used when necessary to prevent imminent serious physical harm to self or others;
- 4) A requirement that restraints and seclusion use is minimal as possible;
- 5) A requirement that all other alternatives have been implemented or rejected before restraints and seclusion are resorted to;
- 6) A requirement that restraint and seclusion use is documented to record when the detainee was restrained, a description of the means of restraint, a description of the behaviour of the patient that required that the patient be restrained, a description of what alternative methods were implemented or rejected before restraint was used, and the estimated length of time the detainee will be restrained for;

- 7) A requirement that the safety and dignity of the detainee is monitored throughout the use of the restraint, and assessed after the use of the restraint;
- 8) A requirement that anyone administering restraints have received training in alternatives to the use of restraints and determining when alternatives are most appropriate, and the use and monitoring of restraints;
- 9) A requirement to inform supported or substitute decision makers when a restraint is used;
- 10) A system for seeking consent from a supported or substitute decision maker for non-emergency, ongoing use of restraints for a detainee who is incapable of consenting to the restraints;
- 11) A system for mandatory reassessment of the need to continue using the restraint at defined periods of time; and
- 12) An administrative body, such as an independent tribunal, with jurisdiction to review the use of restraint and seclusion for compliance with the legal criteria.

Regardless of legislative reform, the **Ministries of Health and Mental Health and Addictions should work in conjunction with the health authorities** to expand and update standardized provincial policies and training regarding the use of restraints and seclusion for *Mental Health Act* detainees that address the issues identified above, such as the practice of some health care providers in using seclusion as a disciplinary measure or for staff convenience.

## NO LEGAL CRITERIA GOVERNING CLOTHING

Although the law is silent on the issue of clothing, facilities in BC have policies or practices that require *Mental Health Act* detainees to remove their clothing on admission and wear hospital gowns/pajamas. Facilities store detainees' clothes and their personal effects, such as wallets, photos, and cell phones, in a locked location that detainees do not have free access to. Wearing clothes is treated not as a right, but as a privilege, and many facilities use access to clothing as a behaviour modification method. For instance, a patient can 'earn' the privilege of wearing clothes by cooperating with staff and can have clothing privileges revoked for 'acting out'. Although most health care providers permit detainees to wear clothes to a Mental Health Review Board hearing, the law is again silent on whether detainees have the right to wear clothes during legal proceedings, leaving it in the hands of individual health care providers.

There are also circumstances in which a detainee's clothes or hospital garments are forcibly removed by health care providers or private security guards. For example, it is a widespread practice that clothes are removed when a detainee is put in seclusion. If a detainee refuses to remove her clothes, health care providers and private security guards will strip her clothes using physical force and then either force her into a hospital gown/pajamas or leave her naked or wrapped in a blanket in seclusion with the hospital gown/pajamas available in the room for the detainee to put on later. The *Guidelines for Secure Rooms in Designated Mental Health Facilities*, however, do not state that patients must be in a hospital gown/pajamas in seclusion. The document states that patients must be "clothed appropriately, with due concern for safety (e.g., removal of potentially dangerous accessories such as belts and shoes)."<sup>34</sup> As another example, the administration of psychotropic pharmaceutical agents often involves removing a detainee's pants and

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<sup>34</sup> *Ibid* at 40.



underwear because injections are often administered in the gluteus. Female detainees have no right to have clothing removal carried out by female health care providers or female private security guards.

In the *Listening* report the Ombudsperson stated that not permitting detainees to wear their own clothes constitutes “a form of psychological restraint, which is no less real than a physical restraint” and that it is “also experienced as “punishment” by many patients.”<sup>35</sup> The report acknowledges that restricting access to clothing may be necessary for controlling behaviour and safety reasons, for instance, a detainee may be less likely to leave the facility without authorization in hospital garments. However, it concludes that the “implications for the patient’s dignity and self-respect suggest that pajama restrictions should be used sparingly. Indeed, one wonders, in the interests of fairness, how many circumstances can justify the measure.”<sup>36</sup>

Unfortunately, the issue has not been addressed since the Ombudsperson’s *Listening* report. In *Increasing understanding of the British Columbia Mental Health Act: preliminary work*, Iva Cheung documented interviews with health care providers who identified some policies and practices, like removing clothes and personal belongings, as punitive rather than therapeutic.<sup>37</sup> A psychiatric nurse stated that unlike patients in other hospital wards, *Mental Health Act* patients are stripped of their clothing, their belongings, and their cell phone, which means patients experience the “restrictive quality of not only the *Mental Health Act* piece but your own personhood in hospital is totally stripped away from you.”<sup>38</sup> She went on to say that this was not mandated by the *Mental Health Act*, but a choice that the facility had made, and she wished “we can find a balance between, you know, making this idea of mental health hospitalization not a punishment or punitive contact with the health care system by giving people back some of the things that make them a little more human.”<sup>39</sup> Other Canadian jurisdictions have taken quite a different approach to the BC default of taking away patients’ clothes. For example, the Yukon *Mental Health Act* guarantees patients the right to receive and wear clothing or other apparel of their choice unless it is likely to endanger the person or endanger or offend others.<sup>40</sup>

The absence of protection for same sex clothing removal for *Mental Health Act* detainees is troubling given how commonly detainees have their clothes removed by health care providers and private security guards. In Canada, we have generally recognized a legal right for detained populations who may be subject to clothing removal by people in positions of authority to be stripped by someone of the same sex. For instance, when a penitentiary staff member conducts a routine visual inspection of the naked body of an inmate, the *Corrections and Conditional Release Act* requires that the inspection be carried out by a staff member of the same sex as the inmate.<sup>41</sup> The same sex requirement may only be waived when a penitentiary staff member believes on reasonable grounds that an inmate is carrying contraband or evidence relating to a disciplinary or criminal offence, and that a strip search is necessary to find the contraband or evidence, and has reasonable grounds to believe that the delay involved in complying with the same sex requirement would result in danger to human life or safety or in loss or destruction of the evidence.<sup>42</sup>

35 *Listening* at 5-35.

36 *Ibid.*

37 Iva Cheung, *Increasing understanding of the British Columbia Mental Health Act: preliminary work* (September 2016) [unpublished].

38 *Ibid* at 69-70.

39 *Ibid* at 70.

40 R.S.Y. 2002, c. 150, s. 40(5)(b).

41 *Corrections and Conditional Release Act*, S.C. 1992, c. 20 [*Corrections and Conditional Release Act*], s. 48; see also *Corrections and Conditional Release Regulations*, SOR/92-620, s. 48.

42 *Corrections and Conditional Release Act*, s. 49(4).

Although forcible clothing removal can be a humiliating experience for anyone, the prevalence of sexual violence against women makes this a particularly frightening experience for female detainees. Women with mental disabilities are sexually assaulted at a higher rate than other women.

Similar protections are in place in the *Safe Care Act* introduced in the BC Legislative Assembly on March 9, 2017, legislation that would permit civil detention in facilities of youth who are suffering from severe drug misuse or addiction or who are likely to be commercially sexually exploited.<sup>43</sup> Under the proposed statute a strip search may only be conducted of youth by a person of the same sex unless the director of the facility believes that the delay that would be caused by complying with this requirement would result in danger to human life or safety.<sup>44</sup> It is anticipated that if this legislation comes into effect, many of the same youth who are currently subject to detention under the *Mental Health Act* could be detained under the *Safe Care Act*. The *Safe Care Act* bill requires that *Mental Health Act* detention must be contemplated before *Safe Care Act* detention is ordered<sup>45</sup> and that a *Safe Care Act* detention can transition into a *Mental Health Act* detention.<sup>46</sup> There is no apparent reason to grant some detainees the right to same sex clothing removal while withholding this right in another setting, particularly when there could be such significant overlap between various forms of detention.

Although forcible clothing removal can be a humiliating experience for anyone, the prevalence of sexual violence against women makes this a particularly frightening experience for female detainees. Women with mental disabilities are sexually assaulted at a higher rate than other women.<sup>47</sup> Female detainees may have experienced sexual assault prior to their detention and may be sexually assaulted in institutions they are detained in.<sup>48</sup> History has many examples of women in institutions being sexually assaulted by other residents, visitors, and staff members.<sup>49</sup> As Maureen Crossmaker points out, women detained in an institution “are reinforced for compliant behavior, economically, physically and psychologically dependent, isolated and lacking in credibility; all factors increasing vulnerability to sexual assault.”<sup>50</sup> While women

43 Bill M 240, *Safe Care Act*, 6<sup>th</sup> Sess., 40<sup>th</sup> Parl., British Columbia, 2017.

44 *Ibid*, s. 35(4).

45 *Ibid*, s. 7(2).

46 *Ibid*, s. 28(3).

47 See, for example, Sandra L. Martin et al, “Physical and Sexual Assault of Women with Disabilities” (2006) 12:9 *Violence against Women* 823 at 823; Douglas A Brownridge, “Partner Violence Against Women with Disabilities: Prevalence, Risk, and Explanations.” (2006) 12:9 *Violence Against Women* 805 at 812; Shana Conroy and Adam Cotter, “Self-Reported Sexual Assault in Canada, 2014” (2017) *Juristat: Canadian Centre for Justice Statistics* 8, 10; Heidi L. Scherer et al “Intimate Partner Victimization Among College Students With and Without Disabilities, Prevalence of and Relationship to Emotional Well-Being” (2014) 31:1 *Journal of Interpersonal Violence* 49 at 66.

48 It is very challenging to estimate how often women are sexually assaulted in institutional settings. The General Social Survey on Victimization conducted by Statistics Canada, for example, excludes respondents living in institutions. See Samuel Perreault and Shannon Brennan, “Criminal Victimization in Canada, 2009” (2010) 30:2 *Juristat*, online: Statistics Canada <<http://www.statcan.gc.ca/pub/85-002-x/2010002/article/11340-eng.pdf>>.

49 Austl, Commonwealth, Australian Centre for the Study of Sexual Assault (ACSSA Wrap No. 10), *Responding to Women's Experiences of Sexual Assault in Institutional and Care Settings*, by Haley Clark and Bianca Fileborn (Melbourne: Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, 2011), online: Australian Institute of Family Studies <<http://www.aifs.gov.au/acssa/pubs/wrap/wrap10/w10.pdf>> [Responding]; Bartley C Frueh et al, “Special Section on Seclusion and Restraint: Patients’ Reports of Traumatic or Harmful Experiences Within the Psychiatric Setting” (2005) 56:9 *Psychiatric Services* 1123 at 1130-1131 (“1130” makes more sense than “113” and is consistent with the contents of the source and the text of this report citing it); Grubaugh et al, “Patients’ Perceptions of Care and Safety Within Psychiatric Settings” (2007) 4:3 *Psychological Services* 193 at 194-195, 197; *People v Thompson*, 142 Cal. App. (4th) 1426, 48 Cal Rptr 3d 803 (Cal. Ct. App. 2006); *R v Harper*, 2002 YKSC 18.

50 Maureen Crossmaker, “Behind Locked Doors: Institutional Sexual Abuse” (1991) 9:3 *Sexuality and Disability* 201 at 205.

are typically treated with doubt and suspicion when they report sexual assault, this is even more acute for women who have been diagnosed with a mental disorder, whose claims of sexual assault are often seen as a delusion or other component of their mental disorder.<sup>51</sup>

In BC, where the majority of psychiatric facilities and wards are staffed by employees of private security companies, clothing removal takes on an even more troubling aspect. An employee of a private company that provides security for settings as diverse as malls, parking lots, and hospitals has not received the same education and training as a health care provider, like a psychiatric nurse. The experience for detainees of having their clothes removed and being touched by a health care provider can be quite different than having the same actions carried out by a security guard who is not there to provide care, but simply to enforce compliance. The 2011 sexual assault prosecution of a Paladin Security employee who engaged in sexual acts with a woman detained under the *Mental Health Act* at Vancouver General Hospital is a sharp reminder of the dangerous power imbalance that exists between female detainees and men in positions of authority around them.<sup>52</sup>

## REPRESENTATIVES REPORTED

Representatives reported that when they saw their clients in facilities they were sometimes wearing their own clothes and sometimes wearing hospital gowns/pajamas. This varied depending on the practice in the ward or facility. For example, representatives reported that for the most part, detainees were made to wear a hospital gown/pajamas on admission but could work their way towards the privilege of wearing clothes with ‘good behaviour’. However, there are some wards or facilities where detainees are never permitted to wear their own clothes. Representatives described the default deprivation of clothes on admission regardless of safety concerns or individual circumstances as “dehumanizing” and “part of the system of control”. One representative described the importance of being permitted to wear clothes in the facility as: “Their clothes are theirs, it’s about independence, it can help them feel different from others.”

A significant concern raised by several representatives was the practice of not permitting detainees to wear clothes at review panel hearings of the Mental Health Review Board. Again, this practice seemed to vary widely across different facilities and regions, with some representatives reporting that all but one or two clients have been permitted to wear clothes at review panels and other representatives reporting that nearly all of their clients had been made to wear a hospital gown/pajamas at a review panel hearing. Representatives expressed two main reasons for concern with not permitting detainees to wear clothes at review panel hearings.

First, many representatives reported that forcing detainees to attend review panel hearings in a hospital gown/pajamas contributed to the already significant stress and feelings of powerlessness for the detainee during the hearing. A review panel is a formal legal procedure where a detainee is faced with a tripartite panel of legal decision makers, a representative presenting the case for detention (who is usually also the patient’s treating psychiatrist), an advocate or lawyer for the detainee, and potentially other attendees, like witnesses or staff in training. Everyone in the room is not only clothed, but clothed professionally. Representatives reported that when detainees are not allowed to wear clothes, they felt “more vulnerable”, “more uncomfortable”, and “less dignified”. One representative reported that she had attended a hearing

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<sup>51</sup> Responding at 4.

<sup>52</sup> *R. v. Alsadi*, 2012 BCCA 183.

**A review panel is a formal legal procedure. Everyone in the room is not only clothed, but clothed professionally. Representatives reported that when detainees are not allowed to wear clothes, they felt “more vulnerable”, “more uncomfortable”, and “less dignified” and that the practice was “horrible” and “demeaning” to detainees.**

where the hospital gown did not even completely cover the detainee’s body. Other representatives said that the practice was “horrible” and “demeaning” to detainees.

Second, many representatives expressed concern for the procedural fairness of a review panel hearing that is conducted with a detainee forced to wear a hospital gown/pajamas. Representatives said that when a detainee comes into the review panel hearing in a hospital gown/pajamas it gives an immediate impression to the review panel members before the hearing even begins that the client is not ready for discharge. Representatives reported that it makes detainees look “less presentable”, “unwell”, “sick”, “badly behaved”, “troublesome”, “like a patient”, and “like someone who belongs in a hospital”. Since clothing is usually an indication of a detainee’s privilege level in the facility and most facilities permit detainees to wear clothes when they’ve earned it, representatives explained that when a review panel sees a detainee in a hospital gown/pajamas it can create problems of bias with tribunal members.

To the representatives who also have experience representing clients in criminal proceedings, the denial of clothes in a legal proceeding was unusual and problematic. For instance, one lawyer explained that it is well established in criminal proceedings that an accused is entitled to wear respectable clothes, even an accused that was being detained in prison, because seeing the accused in prison garments may become a factor in a decision maker’s mind, compromising fairness or the appearance of fairness. Another lawyer reported that this was important both to the accused so that he felt less persecuted because he looked like everybody else in the room, but also for the potential impact it has on a judge. In his view, wearing respectable clothes identified to the judge that the individual has an interest in appearing as a member of society and not as an inmate.

When asked whether they had ever made attempts to challenge a health care provider’s decision that a detainee wear a hospital gown/pajamas at a review panel hearing, several representatives said that they had attempted to challenge the decision, while others had not. For representatives who had experience raising it as an issue with health care providers there were mixed results, with representatives reporting that some health care providers permitted detainees to wear clothes when challenged, while others refused to permit it. One representative reported that he had been told by clients that their doctor said no when they asked if they could wear their own clothes to the panel, but then the doctor agreed to permit it when the legal representative challenged the doctor on his client’s behalf. A few representatives reported that they had raised the issue at the outset of a hearing with review panels, but the panel members said they did not know how to respond to the request or it was up to the treating doctor or the detaining facility.

Finally, several representatives reported that female detainees routinely had their clothes removed by male health care providers or private security guards. Women had expressed to these representatives that this made them uncomfortable and frightened and for detainees who had experienced sexual violence, the experience felt retraumatizing. One representative responded that he had seen efforts made on a ward to have female nurses remove female detainees' clothes, but that these efforts were not consistent. The rest of the representatives responded that they either did not know what efforts were made, or they were under the impression that when private security guards were called to restrain a female detainee or put her in seclusion, whichever guards were available on shift responded without regard to their sex. Representatives reported that the overwhelming majority, or nearly all, of the private security guards they had seen in mental health facilities were men.

## CONCLUSION AND RECOMMENDATIONS

In the absence of clear legal criteria governing the right to wear clothes, detainees across the province are subject to a wide variety of practices and policies depending on which ward or facility they are detained in. As the Ombudsperson concluded, the refusal to permit *Mental Health Act* detainees to wear clothes is a form of restraint, and as such, it should be governed by standardized legal criteria, rather than left to the discretion of detaining facilities. Concerns for the safety of detainees and others should be the only reason why an individual in a facility should be denied the right to wear clothes and the law should reflect and enforce this right.

In addition, the concerns raised by representatives about the impact on detainees and the fairness of the proceedings that may result from refusing to permit detainees to wear their clothes at review panel hearings are extremely troubling. Regardless of the outcome, a review panel hearing is an opportunity for a detainee to present his perspective and feel heard. A hearing can be a therapeutic and important part of recovery and it is therefore critical that it be conducted with dignity and respect for the detainee. Review panel hearing procedures must be fair and seen to be fair. Short of a legislative amendment, the Mental Health Review Board could take steps to address these issues. The Mental Health Review Board has legal authority to control its own process and make rules and orders respecting practice and procedure at review panel hearings.<sup>53</sup> Such authority includes the power to make and enforce rules that detainees have the right to wear clothes during review panel hearings.

Finally, detainees should have the right to same sex clothing removal protected by law like other detained populations in Canada. While there can be an exception to this right if the delay caused by arranging for same sex staff members would result in danger to human life or safety, such circumstances would be rare. There is no meaningful correlation between mental illness and violence,<sup>54</sup> but if there is a safety risk when same sex staff members are not available, other interventions and restraints may be implemented without immediately stripping detainees of their clothes. If private security companies do not currently employ equitable numbers of men and women, the fulfillment of such a right would require initiative and engagement from the Ministry of Health and health authorities to reevaluate how they staff psychiatric wards and facilities. For example, health authorities could choose to staff facilities with more nurses or choose to manage their own security rather than contracting out to private companies to gain better oversight of equitable hiring practices and training. A lack of initiative or oversight of private security

<sup>53</sup> *Administrative Tribunals Act*, S.B.C. 2002, c. 45, ss. 11, 14.

<sup>54</sup> Canadian courts have recognized statistical evidence which establishes that people with mental illness are no more prone to committing violence than others: see for instance *Thompson and Empowerment Council v. Ontario*, 2013 ONSC 5392 at para. 7.

companies are not legitimate reasons for such significant intrusions on detainees' dignity and well-being.

The **BC Government** should review and amend the *Mental Health Act* to establish clear criteria governing the right to wear clothes. Amendments must, as a minimum, address the following:

- 1) A detainee must not be denied clothes in a facility unless the director has reasonable grounds to believe that the denial is necessary for the safety of the detainee or others;
- 2) A detainee has the right to wear clothes during legal proceedings, including review panel hearings of the Mental Health Review Board;
- 3) A detainee must not be denied clothes as a disciplinary measure, a behaviour modification strategy, for staff convenience, or as a treatment method; and
- 4) Clothing removal and physical contact while a detainee is nude must be carried out by someone of the same sex unless the delay caused by compliance with this requirement would result in danger to human life or safety.

Regardless of legislative reform, the **Ministries of Health and Mental Health and Addictions should work in conjunction with the health authorities** to create standardized provincial policies and training on the issues of clothes and clothing removal for detainees. Policies and training must address and correct the current problems reported above, such as the practice of some health care providers to deny a detainee the right to wear clothes as a blanket facility policy, as a disciplinary measure, behaviour modification strategy, or for staff convenience.

The **Mental Health Review Board** should amend its Rules of Practice and Procedures to create a rule that all detainees have the right to wear clothes during review panel hearings unless the detaining facility can demonstrate that wearing clothes during the hearing poses a risk to safety and provide training to review panel members on the enforcement of this right.

## SUMMARY OF RECOMMENDATIONS

### CLOTHING

For the BC Government:

- Review and amend the *Mental Health Act* to establish clear criteria governing the right to wear clothes and the right to same sex clothing removal.

For the Ministries of Health and Mental Health and Addictions in conjunction with the health authorities:

- Create standardized provincial policies and training on the issues of clothes and clothing removal for detainees.

For the Mental Health Review Board:

- Create a rule that detainees have the right to wear clothes during review panel hearings.





# 3 | Access to Information and Legal Advice

## OVERVIEW

**WHEN THE STATE USES ITS POWER** to detain individuals, it is constitutionally obligated to inform the detainees of their legal rights. In the BC civil mental health context, these obligations are articulated in s. 34 of the *Mental Health Act*:

When the state uses its power to detain individuals, it is constitutionally obligated to inform the detainees of their legal rights.

### Notice to involuntary patient

**34** (1) The director must give a notice to a patient on

- (a) the patient's detention in or through a designated facility under section 22 (1), 28 (5), 29 or 42 (1);
- (b) the patient's transfer to a designated facility under section 35;
- (c) a renewal of the patient's detention under section 24.

(2) A notice under this section must be given in writing in the prescribed form and orally and must inform the patient of the following:

- (a) the name and location of the designated facility in or through which the patient is detained;
- (b) the right set out in section 10 of the *Canadian Charter of Rights and Freedoms*;
- (c) the provisions of sections 23 to 25, 31 and 33;
- (d) any other prescribed information.

(3) If the director is satisfied that a patient was unable to understand the information in the notice at the time the notice was given to the patient, the director must give the notice again to the patient as soon as the director considers that the patient is capable of understanding the information in the notice.

The *Mental Health Act* is silent on topics such as whether detainees have the right to communicate with people outside the facility through access to a landline, cell phone, or the internet. The statute does not address detainees' rights to see their advocate or lawyer or any personal visitors. The statute does not grant detainees any privacy rights. There is no administrative body that detainees can seek review from when they experience incursions on privacy or restrictions on communicating with people outside the facility or seeing their legal representative or personal visitors.

The section 10 *Charter* rights referenced in s. 34 of the *Mental Health Act* guarantees that everyone has the right on arrest or detention:

- (a) to be informed promptly of the reasons therefor;
- (b) to retain and instruct counsel without delay and to be informed of that right; and
- (c) to have the validity of the detention determined by way of *habeas corpus* and to be released if the detention is not lawful.

Section 34 requires that individuals are given rights information when they are initially detained under the *Mental Health Act* and after every detention renewal. In practice, the director's obligation to provide rights information is carried out by health care providers in the detaining facility, such as doctors, nurses, and social workers. For detainees who have been placed on extended leave in their community or in an approved home, health care providers, like case managers with community based mental health teams, provide rights information. There is no administrative body that detainees can complain to if there has been a failure in the provision of rights information.

The "prescribed form" referenced in s. 34 of the *Mental Health Act* is Form 13 — Notification to Involuntary Patient of Rights Under the *Mental Health Act* for detainees over the age of 16 or Form 14 — Notification to Patient Under 16, Admitted by Parent or Guardian, of Rights Under the *Mental Health Act*. This research focuses on Form 13, but both forms have similar information. Form 13 is two pages long and states that the person providing the rights information must read selected information in bold type out loud to the detainee. Once the rights information has been read out loud, the detainee is asked to sign the Form 13. The signed copy of the Form 13 is kept on her medical chart and a copy of the Form 13 must be given to the detainee so she has the information in writing.

There are many practical obstacles for communication and access to information for detainees in a facility in BC. The *Mental Health Act* is silent on topics such as whether detainees have the right to communicate with people outside the facility through access to a landline, cell phone, or the internet. The statute does not address detainees' rights to see their advocate or lawyer or any personal visitors. The statute does not grant detainees any privacy rights. There is no administrative body that detainees can seek review from when they experience incursions on privacy or restrictions on communicating with people outside the facility or seeing their legal representative or personal visitors.

This section will begin by discussing the absence of independent rights advice on detention and renewal of detention. The section will consider representatives' experiences of the current quality of rights information provided to detainees as well as their observations of whether detainees are provided copies of the documents they are constitutionally entitled to. The section will then turn to discuss detainees' rights of communication and access to information and representation, including access to a telephone, access to the internet or a cell phone, and in person access to a legal advocate or lawyer.

## NO INDEPENDENT RIGHTS ADVICE ON DETENTION AND RENEWAL

In 1994 the Ombudsperson stated in the *Listening* report: "It is a leading principle of fairness that individuals be informed of their rights and remedies."<sup>1</sup> At the time, the Legal Services Society funded the Mental Health Law Program to provide independent rights advice to all newly admitted patients at Riverview Hospital and to the psychiatric units of several Lower Mainland general hospitals. At these locations, there were protocols in place to notify the Mental Health Law Program when patients were detained and a legal advocate came to the hospital to meet with the patients, provide them with information on their rights and take instructions from them to assist them in exercising their rights. The Ombudsperson expressed concern that independent rights advice was not available elsewhere in BC because several former patients had expressed that "having an independent person tell them of their rights as an involuntary patient made a huge difference to their sense of security and well being."<sup>2</sup>

Unfortunately, since the *Listening* report was written, the independent rights advice program has not expanded to other places in the province, but has been almost completely eradicated. The Legal Services Society cancelled funding for the provision of independent rights advice and hospitals opted out of these voluntary arrangements. The Forensic Psychiatric Services Commission remains the only organization in BC that funds the Mental Health Law Program to provide independent rights advice to detainees at the Forensic Psychiatric Hospital. The Legal Services Society only funds representation at review panels and, as a result, the Mental Health Law Program staff are not funded by the terms of the contract to speak with detainees or their personal supporters who contact the program seeking information about what rights detainees have and how to exercise them. Mental Health Law Program staff may only speak with a detainee who has already applied to the Mental Health Review Board for a review panel hearing, had a hearing scheduled, applied to the Mental Health Law Program for representation, and been assigned an advocate or lawyer.

The Legal Services Society provides funding for individuals who are under criminal investigation, facing criminal charges, or criminally detained to access duty counsel, advice counsel, and the Brydges Line, a province-wide toll-free telephone service to speak to a lawyer 24 hours a day, 7 days a week.<sup>3</sup> The Legal Services Society funds duty counsel for individuals detained in an immigration context at the Canada Border Services Agency's enforcement centre in Vancouver.<sup>4</sup> The Legal Services Society also provides funding in the family law context, which does not involve detention, for individuals to access duty counsel,

1 British Columbia, Office of the Ombudsperson, *Listening: A Review of Riverview Hospital*, Public Report No. 33 (May 1994), online: <<https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2033%20Listening%20A%20review%20of%20Riverview%20Hospital.pdf>> at 4-20.

2 *Ibid.* The *Voices of Experience* survey respondents also unanimously said that advocacy and rights advice should be available to all *Mental Health Act* patients.

3 Legal Aid Services Society, "Legal Advice", online: <[http://www.lss.bc.ca/legal\\_aid/legalAdvice.php](http://www.lss.bc.ca/legal_aid/legalAdvice.php)>.

4 *Ibid.*

advice lawyers, and the Family LawLINE to obtain free legal advice over the telephone from a family lawyer.<sup>5</sup> Yet the Legal Services Society does not fund duty counsel, advice counsel, or a telephone line for individuals detained under the *Mental Health Act*.

The absence of funding for legal advice for *Mental Health Act* detainees means that they have no meaningful access to information and advice outside the staff who work at the detaining facility. Although Form 13 states detainees can ask a nurse or call the Mental Health Law Program with questions about how a review panel works, as discussed, the Mental Health Law Program staff are no longer permitted to speak with detainees who have not already scheduled a review panel and been assigned an advocate or lawyer for representation. This gap in services to detainees is of such a significant concern that a BC non-profit organization, Access Pro-Bono, has recently initiated a summary legal advice telephone program through which people can schedule a phone appointment to speak with a volunteer lawyer about their rights under the *Mental Health Act*.

The result is that detainees are currently provided with rights information by the facility staff who are responsible for and involved in their detention—doctors, nurses, case managers, and social workers. There has long been evidence that this method of communicating rights information to detainees is not working well. For instance, in 2000 it was reported in *Impact Assessment of the Amendments to the Mental Health Act of British Columbia* that among *Mental Health Act* detainees surveyed only 53.5% reported that they know their rights.<sup>6</sup> Only 31.5% of detainees reported being notified of their rights by medical staff upon admission to hospital, the remainder of those who knew their rights reported learning of them through other sources, like advocates.<sup>7</sup> Among health care providers, 80% of doctors and 47% of other care providers involved with rights information provision believed the rights notification process was not effective in any way.<sup>8</sup>

In 2010, the Ministry of Health and six health authorities commissioned a patient experience of care survey to evaluate the short-stay mental health and substance use sector, which was reported on in *Patient Experiences with Short-Stay Mental Health and Substance Use Services in British Columbia*. The *Patient Experiences* report found that “[o]nly slightly more than half of the patients (57%) who were admitted under the *Mental Health Act* indicated that their rights, under the legislation, were explained in a way that could be understood.”<sup>9</sup> A further 35% reported that their rights were not explained in a way that they could understand, while 8% of respondents reported that their rights were not explained to them during their detention at the facility.<sup>10</sup> The explanation of *Mental Health Act* rights was among the bottom three performing items that received the lowest ratings in the patient experiences survey.<sup>11</sup>

In *Increasing Understanding*, Cheung discusses many barriers that exist for facility staff who give detainees rights information. First, she documents interviews with BC health care providers who express concern

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5 *Ibid.*

6 The Adult Mental Health Division, BC Ministry of Health and Ministry Responsible for Seniors, “Impact Assessment of the Amendments to the Mental Health Act of British Columbia”, by Ayne Meiklem (Victoria: 31 March, 2000) at 20.

7 *Ibid.*

8 *Ibid* at 21.

9 R.A. Malatest & Associates Ltd, *Patient Experiences with Short-Stay Mental Health and Substance Use Services in British Columbia*, online: Northern Health, <[https://www.northernhealth.ca/Portals/0/Your\\_Health/Programs/Mental\\_Health\\_and\\_Addictions/documents/BCMHSU-DescriptiveReport-2011.pdf](https://www.northernhealth.ca/Portals/0/Your_Health/Programs/Mental_Health_and_Addictions/documents/BCMHSU-DescriptiveReport-2011.pdf)> at 27. The survey was given to patients with both voluntary and involuntary status under the *Mental Health Act* and asked survey respondents to self select into the rights advice evaluation question by telling respondents to skip the question if they were voluntary patients. Since voluntary patients are not subject to rights deprivations that need explanation, it is possible that the figure of 57% reporting comprehension was made artificially high by voluntary patients mistakenly answering the question.

10 *Ibid* at 16.

11 *Ibid* at 40.

about the lack of education they and other facility staff have received on the *Mental Health Act*.<sup>12</sup> For instance, a psychiatric nurse reported that she had never seen a course, workshop or any information session offered on the topic and that she had primarily learned about the law from the nurses and clinical instructors that she was working with, which meant that she gained a very superficial working knowledge.<sup>13</sup> She said that if someone did develop and offer a *Mental Health Act* training workshop for nurses, “it would be full in a millisecond.”<sup>14</sup> A social worker interviewed stated, “I’ve seen clinicians struggle with how you explain it and make quite evident that they might not understand it completely themselves. Even doctors.”<sup>15</sup>

Second, health care providers have many different responsibilities and demands on their time and the provision of rights information contained on the Form 13 can often be seen as a low priority. Cheung points out that, “[e]xpecting staff, particularly nurses, to advise patients of their rights in a thorough way, in addition to these other responsibilities, may be unrealistic and burdensome.”<sup>16</sup> Given the workload, it is unsurprising then that her interviewees reported that when rights information was provided, the “process is often quite rushed” and rights information providers often failed to check in with the detainee to see how well they understood the information.<sup>17</sup>

Third, regardless of their intentions, tasking health care providers with giving rights information to detainees puts them in a position of conflict. Health care providers are responsible for gaining a detainee’s cooperation with involuntary detention and, almost invariably, involuntary psychiatric treatment. To invest time in ensuring a detainee understands their legal rights and can effectively take steps to enforce them could result in even more tension with the detainee and more work for the health care provider. For instance, a psychiatric nurse Cheung interviewed reported “an apprehension or hesitation to kind of sit down with someone and give them the whole spiel about what it means to be certified under the *Mental Health Act*” and that it’s “easier to say less than to say more.”<sup>18</sup> Finally, it is always possible that rights information is not provided in part or in full. A social worker that Cheung interviewed reported that he had seen facility staff deliver the rights information contained in Form 13 without flipping the form over to cover the information on the second page. He said that in a couple cases he knew from talking to the individuals providing the rights information that they deliberately omitted the second page because they “didn’t want to have to deal with review panel.”<sup>19</sup> Cheung also noted that there are individuals who have experienced involuntary detention who report that they were never given rights information, either orally or in writing.<sup>20</sup>

Health care providers would likely welcome the duty to provide rights information being removed from their responsibilities and tasked instead with an independent rights advisor. The psychiatric nurse that Cheung interviewed said this would “hugely beneficial”<sup>21</sup> and a physician stated that having independent rights advisors would be “the right thing to do.” The physician went on to explain that an independent

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12 Iva Cheung, *Increasing understanding of the British Columbia Mental Health Act: preliminary work* (September 2016) [unpublished] [*Increasing Understanding*] at 22-24.

13 *Ibid* at 24.

14 *Ibid*.

15 *Ibid* at 40.

16 *Ibid* at 36.

17 *Ibid* at 40.

18 *Ibid* at 35.

19 *Ibid*.

20 *Ibid* at 35-36.

21 *Ibid* at 39.

advisor whose sole focus was providing rights information and advice would improve understanding significantly because clinicians have “a split focus, and it’s also a little bit biased.”<sup>22</sup>

In fact, many other Canadian jurisdictions have established independent rights advisors for involuntary patients. For example, the New Brunswick *Mental Health Act* creates a system in which the administrator of a psychiatric facility must give notice to the appropriate psychiatric patient advocate service on certain triggering events, which include each involuntary detention in a psychiatric facility.<sup>23</sup> The Psychiatric Patient Advocate Services of New Brunswick is an independent agency that operates to “inform patients of their rights, to represent them at Tribunal and/or Review Board hearings, and to ensure that the *Mental Health Act* and the rights of patients be respected at all times.”<sup>24</sup>

The Nova Scotia *Involuntary Patients Treatment Act* sets out a framework for a patient-advisor service and mandates that a patient advisor must not be employed by or have privileges at a health authority.<sup>25</sup> The statute requires a chief executive officer responsible for the administration and management of a health authority to notify the patient-advisor service of certain triggering events, including a decision to admit a person as an involuntary patient and a renewal in respect of an involuntary patient.<sup>26</sup> A patient advisor must meet with an involuntary patient as soon as possible to, among other things, explain the significance of the situation, identify available options, assist the patient in making an application to the Review Board, and assist in obtaining legal counsel, if requested, and applying for legal aid.<sup>27</sup>

In Ontario, the Psychiatric Patient Advocate Office provides rights advice, education, and advocacy services to people in mental health facilities, and responds to approximately 25,000 certificates issued every year.<sup>28</sup> This role is protected through several provincial statutes, including the Ontario *Mental Health Act*, which requires that a physician who completes an involuntary certificate must promptly notify a rights advisor who then meets with the patient to provide rights advice and assistance in applying for review and obtaining legal services.<sup>29</sup> The Psychiatric Patient Advocate Office states that “Rights Advice ensures that mental health patients who have had their legal status changed as an involuntary or incapable patient are afforded the same protection under the *Canadian Charter of Rights and Freedoms* as any other citizen, including the right to life, liberty and security of the person; the right not to be arbitrarily detained or imprisoned; and the right upon detention to be informed of the reasons for detention, to retain legal counsel without delay, and to challenge the reasons for their detention.”<sup>30</sup>

Finally, in Newfoundland and Labrador, the *Mental Health Care and Treatment Act* establishes a framework for rights advisors, who must not be involved in the person’s direct clinical care and who do not provide treatment, care and supervision under a community treatment plan.<sup>31</sup> The administrators of a psychiatric unit must notify rights advisors when, among other things, a person is admitted or detained in a psychiatric unit and on the filing of each certificate in respect of an involuntary patient.<sup>32</sup> A rights advisor fulfills

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22 *Ibid.*

23 R.S.N.B. 1973, c. M-10, s 7.6.

24 The Psychiatric Patient Advocate Services of New Brunswick, “Psychiatric Patient Advocate Services”, online: <<https://www.gnb.ca/0055/advocate-e.asp>>.

25 S.N.S. 2005, c. 42, s 60(2).

26 *Ibid.*, s. 62.

27 *Ibid.*, s. 61(2).

28 Psychiatric Patient Advocate Office, “About the PPAO” [About the PPAO], online: <<https://www.sse.gov.on.ca/mohltc/ppao/en/Pages/AboutthePPAO.aspx>>.

29 R.S.O. 1990, c. M.7, s. 38.

30 *About the PPAO*.

31 S.N.L. 2006, c. M-9.1, s. 13.

32 *Ibid.*, s. 15.



several functions, including meeting with involuntary patients within 24 hours of their admission to offer advice and assistance, explain the significance of a certificate of involuntary admission, assist with applications to the Mental Health Care and Treatment Review Board and assist with obtaining legal counsel.<sup>33</sup>

As these examples from other Canadian jurisdictions demonstrate, the absence of independent legal advice and information for detainees means the BC mental health system is, once again, behind national best practices. In addition, Article 13 of the UN CRPD requires that state parties ensure effective access to justice for persons with disabilities on an equal basis with others in order to facilitate their effective role as participants in all legal proceedings and that state parties must promote appropriate training for those working in the field of administration of justice. In *Equality, Dignity and Inclusion*, Froese argues that the BC *Mental Health Act* does not comply with Article 13 in failing to establish an independent advocate to perform duties such as informing persons living with a mental illness of their legal rights and providing advocacy and support to assist them to exercise their legal rights.<sup>34</sup>

The BC *Mental Health Act* is also vulnerable to criticism for its failure to adequately address when detainees must be informed of their rights. Froese reported that unlike many other Canadian mental health statutes, the BC *Mental Health Act* fails to expressly state that patients must be informed of their rights as soon as possible after involuntary admission.<sup>35</sup> Cheung similarly pointed out that the BC *Mental Health Act* is silent on the timing of rights notification.<sup>36</sup> The Alberta Mental Health Patient Advocate has been vocal in her criticism of the Alberta *Mental Health Act* for authorizing the police to apprehend and convey individuals to a facility for examination with no statutory requirement to inform these detained individuals of their rights.<sup>37</sup> She concluded that such a legislative gap is a violation of the *Charter* and calls for the Alberta statute to be amended to ensure the rights of all detained persons subject to the statute are protected.<sup>38</sup> The BC *Mental Health Act* also grants police authority to apprehend and immediately take a person to a physician for examination pursuant to s. 28(1) with no explicit requirement that detainees be informed of their rights when apprehended by police.

## REPRESENTATIVES REPORTED

### Quality of Rights Information

In assessing the efficacy of rights information provided to detainees by health care providers through this research, it is important to note that, for the most part, the legal representatives interviewed only had experience with detainees who they were representing at a review panel hearing. To meet with an advocate or lawyer to prepare for a review panel requires that detainees have already learned information about the option of review panels, applied to the Mental Health Review Board for a hearing, have a hearing scheduled, and applied for an advocate or lawyer to represent them at the hearing. By definition, a participant pool of advocates and lawyers who represent clients at review panels is a sample that will primarily have observations only of detainees who already have a certain level of information and have

33 *Ibid*, s. 14.

34 British Columbia, *Equality, Dignity and Inclusion: An Evaluation of British Columbia's Mental Health Laws, Policies and Service Standards*, by Beverly Froese, in Report to the Law Foundation of British Columbia (Victoria: 31 March 2017) [*Equality, Dignity and Inclusion*] at 37-38.

35 *Ibid* at 35-37.

36 *Increasing Understanding* at 41-42.

37 Alberta Mental Health Patient Advocate, "Alberta Mental Health Patient Advocate 2014-2015 Annual Report" (Edmonton: Office of the Alberta Health Advocates, 2015), online: <<https://www.albertahealthadvocates.ca/resources/Documents/Annual%20Reports/Mental%20Health%20Patient%20Advocate/MHPA%20Annual%20Report%202014-2015.pdf>>.

38 *Ibid* at 37.

already exercised their right to a review panel. This research does not document circumstances in which detainees have not been provided with adequate information and assistance to even apply for a review panel.

Nevertheless, many representatives raised concerns about the quality and consistency of rights information provided to detainees by health care providers. They reported that many of their clients seemed to lack information on their rights under the *Mental Health Act*. Representatives acknowledged that it was challenging for them to know why a client was lacking information on their rights because they usually were not present when a detainee was provided with the information. A detainee could lack information on their rights for a number of reasons, for instance, it was never provided to them, it was provided in a way the detainee did not understand, the detainee was given the information but subsequently forgot, or it was provided at a time when detainees could not engage with the information and then it was not provided again when the detainee was ready to engage with the information. However, there were such widespread knowledge gaps reported amongst detainees that at least some of this must be attributable to the way the information was delivered or the fact that the information was not provided at all. In addition, some representatives had direct observations because they were present when health care providers gave rights information to their client or other detainees in the facility.

Most representatives reported that it was their impression that health care providers giving rights information generally seem to understand what a review panel is and how to apply for one and convey that information to detainees. However, several representatives expressed concern that health care providers do not appear to understand and be able to educate detainees on other rights, such as *Charter* rights, *habeas corpus* court applications, s. 33 *Mental Health Act* court applications, and the *Mental Health Act* s. 31(2) right to a second medical opinion. Information on review panels is by no means universally understood and conveyed, however. Some representatives reported that when the Legal Services Society used to fund the Mental Health Law Program to provide legal information and advice they received numerous phone calls from patients detained in a facility who did not know what a review panel was or how to apply for one. One representative observed that although Form 13 states that detainees can ask a nurse questions about how review panels works, when detainees ask facility staff about their legal rights, the facility staff often tell them to call the Mental Health Law Program with their questions.

Many representatives said that it appeared as if the rights information provided was “inadequate”, “pro-forma”, and as minimal as possible. Some representatives raised the concern that rights information was often provided when a detainee could not meaningfully engage with the information because they were unwell or under the influence of substances on admission, but the rights information was not repeated later when a detainee could better understand the information, as required by the legislation. Two representatives observed that it seemed like more passive detainees were more likely to be missing information, whereas the detainees who knew more were “squeaky wheels” who had asked a lot of questions. Some representatives responded that while detainees may have been told what their rights were, the impression they gathered was that the facility staff, who were often busy with other job demands, were not always helpful in providing a detainee with assistance to exercise their rights.

A significant concern raised by several representatives was that the obligation to provide rights information was more likely to be forgotten or skipped on renewal of detention than following the initial admission.<sup>39</sup> This is particularly problematic for detainees who are living in the community on extended leave. While health care providers who work in a hospital where certificates are routinely completed may

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39 The BC *Mental Health Act*, s. 34(1)(c) states that rights information must be provided on renewal of detention.

be more familiar with the statutory process of providing rights information, a community based mental health team or the staff in a long-term care facility with only one or two residents detained under the *Mental Health Act* may have less training and familiarity with the process. Several representatives had met clients who had been in the community on extended leave for many certification renewals who had no idea until recently that they were entitled to a review panel while on extended leave. One representative recounted an example of a community based mental health team member documenting in records that an involuntary patient on extended leave expressed a desire to go to a review panel, but the member did not have the form to request a review panel from the Mental Health Review Board. Several weeks had elapsed before the mental health team followed up to provide the individual with the appropriate form to request a review panel.

Some representatives expressed the perspective that it was neither effective nor appropriate to task health care providers with delivering legal information. For instance, some representatives stated that while they think most facility staff who deliver rights information try their best, it is difficult for facility staff to convey legal information when they have not had legal training and may have varying degrees of understanding of the law themselves. Others identified that it was a conflict of interest that facility staff who are actively involved in monitoring detainees' behaviour, documenting it in medical records, and contributing to detention and discharge decisions are also the same individuals that detainees have to seek legal information from. One representative articulated that it was disturbing that detainees have to ask for legal advice from the same people who have the power to decide if you will be detained or discharged, when you eat and bathe, and whether you will be put in seclusion. Several representatives reported that some health care providers perceive detainees' questions about their legal rights or the decision to request a review panel as an indication that they lack insight into their mental illness, a topic that will be discussed further in section 5 | [Scheduling and Preparing for a Review Panel Hearing](#). From these representatives' perspective, the relationship between the detaining facility staff and a detainee is not a relationship of trust where detainees feel like they can freely ask questions about their legal rights without it being documented or relied on by the detaining authorities.

### *Mental Health Regulation Forms*

When asked whether their clients were consistently given copies of the written reasons for detention in Form 4 or for detention renewal in Form 6 and the notification of rights in Form 13, there were mixed responses. Representatives reported that Form 13 was generally on the medical chart, but it was often unsigned, with no indication of why it was unsigned, which makes it challenging to evaluate whether detainees were provided with their rights information orally or in writing or not at all. Some representatives reported that they have seen medical charts where the Form 13 was completely missing, and this was particularly common following a renewal certificate. It is difficult to know the reasons for a missing Form 13 — it could be because the form was not completed and put on the chart, but it could also be because the Form 13 was on the chart at one point, but was not copied over when a detainee was transferred to a different facility or the Form 13 was destroyed when the chart was 'thinned' at some point in time.

Some representatives raised concerns that when the information on Form 13 was read out loud to detainees, facility staff often treated that as if the statutory duty to provide rights information was fulfilled. For instance, some representatives said that although it seemed like Form 13 is usually read to detainees, they are almost never given a copy of it. Others said that it seemed that detainees were simply shown a Form 13 and asked to sign it, but no one explained what it meant. One representative reported that he

had heard from clients that they were frightened to sign a Form 13 because they were unsure whether it would prejudice them in some way. Finally, although s. 5 of the *Mental Health Regulation* requires that a copy of the *Mental Health Act*, sections 1 to 10 of the regulation, and Forms 13 and 14 be posted in a conspicuous place that is accessible to patients in the facility, some representatives said that the legally required information was almost never posted in facilities.

Several representatives reported that they had never seen a detainee provided with copies of their Form 4s and 6s that set out the reasons for their detention. Some representatives said they had only seen that requirement fulfilled on one or two rare occasions. Representatives reported being told by staff at detaining facilities that it was facility policy that detainees were not permitted to see copies of their records or that they were only entitled to request copies of the records on discharge. Several representatives said that their clients usually have no idea what the reasons for detention were and when they show their clients copies of their medical records in preparation for a review panel hearing, their clients are often quite surprised by the reasons recorded on the Form 4s and Form 6s.

The failure to provide detainees with copies of the written reasons for their detention is not particularly surprising given that detainees are routinely denied access to their own medical records, which will be described in more detail below in section 5 | [Scheduling and Preparing for a Review Panel Hearing](#). When representatives pointed out to staff at a detaining facility that their client had a legal right to see the written reasons for their detention, they were usually met with a great deal of resistance. Some representatives reported that they were told that the facility never permits patients to see their own medical records and the facility needed no justification for withholding the information. One representative was told that it was facility policy that they would only show patients typed notes and would not show patients any document with handwritten notes on it, a troubling policy given that nearly all forms pursuant to the *Mental Health Regulation* are completed in handwriting by health care providers.

## CONCLUSION AND RECOMMENDATIONS

It is clear that tasking health care providers with communicating legal information to detainees is not functioning for either health care providers or detainees. To deliver rights information, facility staff need a working knowledge of the *Charter*, several provisions of the BC *Mental Health Act*, legal proceedings at an administrative tribunal, statutory court applications, and court applications based on an ancient and rarely used prerogative writ which forms part of a superior court's inherent jurisdiction. Health care providers lack the necessary education, training, and time to fulfill these obligations. The observations of the representatives that health care providers do not understand how to convey legal information about s. 33 *Mental Health Act* applications and *habeas corpus* applications is borne out by how rarely detainees manage to bring these applications to court. Since the last significant amendments were made to the BC *Mental Health Act* in 1998, there has only been one published decision from the BC Supreme Court of a s. 33 application<sup>40</sup> and no published *habeas corpus* decisions<sup>41</sup> among the tens of thousands of people detained in designated facilities in the nearly 20 year time span. The absence of court supervision of *Mental Health Act* detention will be discussed in section 7 | [Oversight and Accountability](#).

<sup>40</sup> *N.T. v. Facility*, 2012 BCSC 1162.

<sup>41</sup> The only published *habeas corpus* application under s 10(c) of the *Charter* by someone who had been certified under the *Mental Health Act* is *R. v. Anderson*, 2014 BCSC 395, however, Mr. Anderson was an accused person who was being held in a correctional facility. His application was dismissed because he was not actually applying for release, but to be transferred to a hospital.

## SUMMARY OF RECOMMENDATIONS

### INDEPENDENT RIGHTS ADVICE

For the BC Government:

- Review and amend the *Mental Health Act* to create a statutory framework for prompt, independent rights advice on detention and detention renewal.

For the Legal Services  
Society:

- Provide funding for detainees to access legal advice on detention and detention renewal.

For the Ministries of Health  
and Mental Health and  
Addictions in conjunction  
with the health authorities:

- Create standardized provincial policies and training for health care providers who provide rights information to detainees.

But on a more fundamental level, it is a conflict of interest for facility staff who are involved in detention and involuntary treatment decisions to provide rights information to detainees. Detainees cannot freely ask questions about their rights and seek legal advice from the same individuals who are actively monitoring and documenting their behaviour. Anything a detainee says to a health care provider can be recorded and form a part of the basis for prolonged detention and involuntary treatment. This would be analogous to expecting individuals who are criminally detained to ask for legal advice from the police rather than a lawyer. Mental health statutes in other Canadian jurisdictions recognize this conflict of interest by explicitly prohibiting individuals who are involved in detention or who are employed by, or have privileges with, a health authority from providing rights information to detainees.

Given the significant *Charter* interests at stake, BC must address the substantial deficiencies in rights advice to detainees by creating a statutory framework for independent rights advice. Pending a legislative amendment, the Ministry of Health and health authorities could take the initiative to evaluate the efficacy of rights information provision and create better policies and training for facility staff who are responsible for providing rights information. For instance, the health authorities could provide a training course to a specific group of health care providers to provide rights information and only those who have received the training would be able to provide rights information.

The **BC Government** should review and amend the *Mental Health Act* to create a statutory framework for prompt, independent rights advice. Amendments must, as a minimum, address the following:

- 1) A protected role for an independent organization to provide rights advice to detainees as appointed by the Minister;
- 2) Sufficient safeguards to ensure that rights advisors are independent from the detaining facility and health authority;
- 3) A process that requires the director or delegates to immediately notify rights advisors when a detainee is apprehended or detained;
- 4) Timing requirements that addresses a process for promptly informing detainees of their rights on all methods of apprehension and detention; and
- 5) Provision of adequate funding to the independent organization responsible for providing rights advice.

Regardless of legislative reform, the **Legal Services Society** should provide funding for detainees to access legal advice through duty counsel or an independent organization, or at the least, a toll-free telephone line staffed with legal advocates or lawyers.

Regardless of legislative reform, the **Ministries of Health and Mental Health and Addictions should work in conjunction with the health authorities** to create standardized provincial policies and training of health care providers who are currently responsible for providing rights information to detainees. Policies and training must address and correct the current deficiencies in rights information provision reported above, such as the failure to repeat rights information at a time when detainees can better understand the information and the failure to provide rights information after detention renewal.

## COMMUNICATION AND ACCESS TO INFORMATION AND REPRESENTATION FOR DETAINEES IN A FACILITY

There are many practical obstacles for communication and access to information and legal representation for detainees in a facility in BC. The *Mental Health Act* is silent on topics such as whether detainees have the right to communicate with people outside the facility, whether detainees have the right to see their advocate or lawyer or any personal visitors, and whether detainees have privacy rights. There is no administrative body that detainees can seek review from when they experience incursions on privacy or restrictions on communicating with people outside the facility or seeing their legal representative or personal visitors.

BC is once again behind the national and international standards in its failure to address communication, in person access, and privacy for *Mental Health Act* detainees. Many other Canadian jurisdictions explicitly address these issues in their mental health statutes, particularly detainees' right to see their lawyer or advocate in person at any time. For example, the Northwest Territories' *Mental Health Act* states that a patient may communicate by telephone with a lawyer at any time and a lawyer acting for a patient may visit the patient at any time.<sup>42</sup> The Yukon *Mental Health Act* states that no patient can be denied the right to see their legal representative or agent at any time if they are at the hospital to see the patient.<sup>43</sup> The Alberta *Mental Health Act* guarantees that a lawyer acting for a patient may visit the patient at any time.<sup>44</sup> Examples of how other Canadian statutes address communication, in person access, and privacy are set out in more detail below.

Newfoundland and Labrador's *Mental Health Care and Treatment Act*<sup>45</sup> states:

- 12.** (1) A person who is an involuntary patient shall not be denied
- (a) the right to consult and instruct his or her legal counsel in private at any time either in person or by other means;
  - (b) access to a telephone to make or receive calls;
  - (c) access to visitors during scheduled visiting hours;
  - (d) access to the rights advisor;
  - (e) access to his or her representative; and
  - (f) access to materials and resources necessary to write and send correspondence, and reasonable access to correspondence that has been sent to the person.

<sup>42</sup> R.S.N.W.T. 1988, c. M-10, s. 38.

<sup>43</sup> R.S.Y. 2002, c. 150, s. 40(4).

<sup>44</sup> R.S.A. 2000, c. M-13, s. 16(2).

<sup>45</sup> S.N.L. 2006, c. M-9.1, s. 12. (1).



Prince Edward Island's *Mental Health Act*<sup>46</sup> guarantees that no patient who is in a psychiatric facility may be denied:

- 33** (2)(a) reasonable access to a telephone to make or receive calls;
- (b) reasonable access to any person who is visiting him or her during scheduled visiting hours;
- (c) access at any time to the following people provided that they are at the facility to see the patient:
- (i) the patient's representative or agent,
  - (ii) the patient's guardian;
  - (iii) any other person authorized by the Minister; or
- (d) reasonable access to materials and resources necessary to write and send correspondence, and reasonable access to any correspondence which may have been sent to the patient.

In addition, Prince Edward Island's mental health review board has jurisdiction to review unreasonable denials of a patient's communication rights.<sup>47</sup>

Section 17 of Québec's *An Act respecting the protection of persons whose mental state presents a danger to themselves or to others*<sup>48</sup> states:

**17.** A person under confinement must be allowed to communicate freely and confidentially with the persons of his choice, unless the attending physician decides, in the interests of the person under confinement, to prohibit or restrict certain communications.

A prohibition or restriction as to communication can only be temporary. It must be set out in writing and contain reasons, and it must be given to the person under confinement and noted in his record.

No restriction may, however, be imposed on communications between the person under confinement and his representative, the person qualified to give consent to the care required by his state of health, an advocate, the Public Curator or the Administrative Tribunal of Québec.

Communication and privacy rights are also addressed in the BC *Safe Care Act* introduced in the BC Legislative Assembly on March 9, 2017, legislation that would permit civil detention in facilities of youth who are suffering from severe drug misuse or addiction or who are likely to be commercially sexually exploited.<sup>49</sup> Under the bill a child who is detained in a safe care facility has the right to reasonable privacy and to possession of his or her personal belongings, as well as an explicit right to privacy during discussions with the child's lawyer.<sup>50</sup> It is anticipated that if this legislation comes into effect, many of the same youth who are currently subject to detention under the *Mental Health Act* could be detained under the *Safe Care Act*. The *Safe Care Act* bill requires that *Mental Health Act* detention must be contemplated before a *Safe Care Act* detention is ordered<sup>51</sup> and that a *Safe Care Act* detention can transition into a *Mental Health Act* detention.<sup>52</sup> There is no apparent reason to grant some detainees communication and privacy rights

46 R.S.P.E.I. 1988, c. M-6.1.

47 *Ibid*, s. 28(1).

48 *An Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others*, CQLR c P-38.001, s. 17.

49 Bill M 240, *Safe Care Act*, 6<sup>th</sup> Sess., 40<sup>th</sup> Parl., British Columbia, 2017.

50 *Ibid*, s. 25.

51 *Ibid*, s. 7(2).

52 *Ibid*, s. 28(3).

while withholding this right in another setting, particularly when there could be such significant overlap between various forms of detention.

The BC *Mental Health Act*'s failure to address communication, in person access, and privacy for *Mental Health Act* detainees raises compliance concerns with several UN CRPD requirements. For instance, Article 21 requires State Parties to take appropriate measures to ensure that persons with disabilities are able to exercise their right to freedom of expression and opinion and the right to access information. Article 22 requires State Parties to protect the privacy of personal, health and rehabilitation information of persons with disabilities and prohibits arbitrary or unlawful interference with a person's privacy and correspondence or other types of communications regardless of place of residence or living arrangements. In *Equality, Dignity and Inclusion* Froese found that the BC *Mental Health Act* fails to expressly recognize the right of persons living with a mental illness to freedom of expression and opinion, and the freedom to seek, receive and impart information.<sup>53</sup> She further concluded that the right to privacy in mental health facilities, including but not limited to privacy prior to and during admission (voluntary or involuntary), a private room and private storage space, uncensored correspondence, and privacy for visits and telephone conversations is not at all addressed in the BC statute.<sup>54</sup>

## REPRESENTATIVES REPORTED

### Access to Telephones, Cell Phones, Internet, and Correspondence

Facilities in BC typically have one phone per ward available for all the patients to use, so it is not surprising that representatives identified many challenges to communicating with their clients who were detained in facilities. For instance, nearly all the representatives reported that they had encountered difficulties in contacting their clients over the phone because of issues such as the patient phone line being busy, another patient who was not their client answering the phone and not passing on messages to their client, multiple patients waiting to use the phone limiting the available time, or ward scheduling conflicts. However, several representatives reported more deliberate interruptions in the patient phone line. For example, after failing to get through to a client on the patient line multiple times some representatives reported calling the ward nursing station and being told that the patient phone was unplugged because one patient was overusing the phone. Other representatives reported being told by nurses that they had unplugged the patient phone at night and forgotten to plug it back in again the next morning. As one representative phrased it, "access to the phone is a privilege, not a right."

Representatives reported that for the most part facility staff are responsive in facilitating communication when they tried to contact their client. However, some representatives reported that they had experienced resistance from facility staff in trying to communicate with their clients. For instance, some representatives reported that some ward staff had refused to permit them to speak with their clients over the phone when they were in seclusion. Other representatives reported that occasionally when they had failed to get in touch with their client several times over the patient line and called the nursing line as a last resort, the nurses refused to pass the phone to the detainee and insisted that they keep trying the patient line. One representative who works in both the civil and criminal mental health systems observed that staff in forensic mental health facilities had a much better understanding of the importance of patients being

<sup>53</sup> *Equality, Dignity and Inclusion* at 102.

<sup>54</sup> *Ibid* at 104.

able to speak freely with their advocate or lawyer, whereas staff in the civil mental health system were much more likely to interfere with this communication.

Representatives reported that nearly all facilities locate the patient phone in a public or common area of the facility, often in close proximity to the nursing station. Representatives reported seeing only one or two facilities which provided a private, enclosed space for the patient phone. Many representatives reported that they often have to avoid substantive conversations over the phone because of the chance their clients' communication is being overheard by facility staff. When a conversation must take place over the phone, many representatives reported that this raised significant concerns about the privilege of their communications with their clients given that facility staff could overhear and even document what detainees say. For instance, representatives said that detainees often have to be careful about what questions they can ask and censor what they say to their lawyer or advocate over the phone because of the presence of other patients or facility staff who could overhear them. As one representative framed it, there is no presumption of privacy on psychiatric units and this lack of privacy negatively impacts detainee's ability to access legal advice.

Some representatives reported seeing notes recorded in a detainee's medical chart that facility staff had listened to privileged communications between a detainee and their lawyer or advocate and recorded both the content of what the detainee said as well as the detainee's tone in the conversation. For example, one representative reported seeing documentation in a detainee's chart that the treating psychiatrist would not permit the detainee to speak privately with the police even though she was a victim in an ongoing active investigation, and instead the psychiatrist had insisted on being present to listen in on the phone call. Another representative reported that she had a client whose treating psychiatrist listened in on communication between her and her client and documented it in a report. At the Mental Health Review Board hearing the panel chair identified that this was an inappropriate incursion on legally privileged communications and allowed the advocate to redact the content from the copy of the report. However, after the hearing when the advocate took steps to ensure that the breach of privilege was removed from the detainee's medical records, the psychiatrist refused to remove the content from the records, which means that privilege will continue to be breached over and over again every time someone looks at the detainee's medical records.

Most representatives reported that they had observed that facilities generally take cell phones away from detainees on their admission and kept the cell phones at the nursing station. Detainees were permitted to have access to their phones as a privilege at the discretion of the facility staff. For example, several representatives had observed that detainees were sometimes permitted to have access to their cell phones when out of the facility on a day pass. Representatives reported that only some facilities had a computer that detainees could use to access the internet, but the majority of facilities did not. In facilities with a computer, using it was a privilege a detainee could 'earn', rather than a right.

It is clear that access to the internet or cell phones is inconsistently granted to detainees, even to carry out important tasks, such as organizing evidence to use at upcoming Mental Health Review Board hearings. Some representatives reported that some of their clients had access to the internet either through a ward computer or through a cell phone because they forwarded emails to them to use as evidence at hearings. However, one representative reported that his client was not permitted to use the internet to contact someone to come to an upcoming hearing to give evidence as a witness. Another representative reported that her client was denied access to the internet to get a phone number from a Facebook message to confirm accommodation arrangements for creating a discharge plan in preparation for a review panel hearing.

Finally, some representatives expressed concern that detainees were not always given correspondence that was sent to them at detaining facilities. These representatives reported that while reviewing detainees' medical records they had found unopened legal correspondence that they had mailed to the detainee at the detaining facility that was never provided to the detainee.

### In Person Access to Advocate or Lawyer

Representatives reported that there are generally few problems with being granted in person access to their clients in facilities. The issues representatives had encountered were not necessarily a denial of access, but a reluctance to grant access or a denial of private access. For instance, several representatives reported that detaining facility staff had tried to be present in the room when giving their client legal advice and the lawyer or advocate had to insist that the communication was legally privileged and the health care provider could not be present. Other representatives reported that health care providers have tried to leave the door to a meeting room open with facility staff outside the door. Some representatives said that they had the impression that facility staff were nervous or displeased with the presence of a lawyer or advocate in the facility.

By far the most common reason representatives reported for being denied access to their client was when a facility would not permit detainees in seclusion to see their lawyer or advocate. Facilities take a variety of different approaches to permitting detainees in seclusion access to their lawyer or advocate, with responses ranging from not permitting any access whatsoever to allowing representatives to speak with their clients with the seclusion room door open and facility staff or security guards present. Many representatives had been incredibly determined and creative in their attempts to communicate with their clients in seclusion, for instance, successfully advocating to speak with their client through the closed seclusion room door or passing notes or forms under a closed seclusion room door. These representatives highlighted that speaking with clients in seclusion presents an almost certain incursion on legal privilege and that having other facility staff present hindered their ability to have an open conversation with their client and give them legal advice. For example, one representative reported that the psychiatric nurse who was present while she was giving legal advice to her client in seclusion later presented the facility's case for detention at the review panel hearing, which created a significant violation of procedural fairness.

## CONCLUSION AND RECOMMENDATIONS

When you are involuntarily detained in mental health facilities, facility staff have absolute control over where you go, what you wear, what and when you eat, when you bathe, when you sleep, what restraints you are placed in, whether you are placed in seclusion, and which psychiatric treatment you are administered. This situation of complete powerlessness can be incredibly frightening for detainees and made even more so when your ability to communicate with people outside the facility and access information is also restricted. It is critical that there are clear legal criteria that recognize detainees' rights to privacy, communication, and access to information and establish the circumstances under which these rights can be restricted.

The constitutional right to retain and instruct counsel without delay on detention is only meaningfully fulfilled when detainees are granted access to a legal representative. The ability to speak freely with your lawyer is a fundamental cornerstone in a fair and transparent legal system which we solicitously protect

## SUMMARY OF RECOMMENDATIONS

### COMMUNICATION AND ACCESS TO INFORMATION AND REPRESENTATION

For the BC Government:

- Review and amend the *Mental Health Act* to address detainees' rights to communication, in person access, and privacy.

For the Ministries of Health and Mental Health and Addictions in conjunction with the health authorities:

- Create standardized provincial policies and training to ensure that health care providers respect detainees' rights to communication, in person access, and privacy to address problems such as breaching detainees' legally privileged communications.

with solicitor-client privilege. But in the absence of clear statutory direction, *Mental Health Act* detainees are routinely deprived of these rights in BC. Detainees have been denied access to their legal advocate or lawyer and have had their solicitor-client privilege breached by the facility staff responsible for their detention. With no independent rights advice provided to detainees upon detention, the need to speak openly and seek legal advice from an advocate or lawyer in preparation for a Mental Health Review Board Hearing becomes even more critical.

The **BC Government** should review and amend the *Mental Health Act* to address statutory rights to communication, in person access, and privacy. Amendments must, as a minimum, address the following:

- 1) Detainees' right to private access to telephone, cell phone, and internet communication and the circumstances, if any, under which access can be restricted;
- 2) Detainees' right to see visitors and the circumstances, if any, under which the right to see visitors can be restricted;
- 3) Detainees' right to uncensored and private correspondence;
- 4) Detainees' right to privacy and the circumstances, if any, under which it can be restricted;
- 5) An absolute right for a detainee to communicate with and meet in person with their advocate or lawyer in private at any time.

Regardless of legislative reform, the **Ministries of Health and Mental Health and Addictions should work in conjunction with the health authorities** to create standardized provincial policies and training to ensure that health care providers understand and respect detainees' rights to privacy, communication, and access to information. Policies and training must address and correct the current violations reported above, such as the practice of some facilities in denying communication and in person access to a detainee's lawyer or advocate and the practice of some health care providers of breaching a detainee's legally privileged communications.

# 4 | Psychiatric Treatment

## OVERVIEW

**THE RIGHT TO GIVE, REFUSE, AND REVOKE CONSENT** to medical treatment is a fundamental principle in Canadian law. In *Malette v. Shulman*,<sup>1</sup> the Ontario Court of Appeal held that "...a medical intervention in which a doctor touches the body of a patient would constitute a battery if the patient did not consent to the intervention. Patients have the decisive role in the medical decision-making process. Their right of self-determination is recognized and protected by the law."<sup>2</sup> Health care consent rights govern the treatment of mental illness as well as physical illness. In *Starson v. Swayze*,<sup>3</sup> the Supreme Court of Canada ruled that "[t]he right to refuse unwanted medical treatment is fundamental to a person's dignity and autonomy. This right is equally important in the context of treatment for mental illness."<sup>4</sup>

In BC, health care providers must not provide health care without obtaining consent.<sup>5</sup> Every adult is presumed to be capable of giving, refusing, or revoking consent to health care until the contrary is demonstrated through a capacity assessment.<sup>6</sup> If a health care provider assesses an individual as incapable of making a health care decision, health care providers must seek consent to provide health care from a supported or substitute decision maker.<sup>7</sup> Adults can make a legal document called a Representation Agreement to appoint a family member or friend to make decisions on their behalf as a Representative when they are incapable.<sup>8</sup> If an adult is found incapable and there is no Representative authorized through a Representation Agreement, health care providers must choose a Temporary Substitute Decision Maker to make a health care decision for the adult. Sometimes people refer to Temporary Substitute Decision Makers as "next of

*In Starson v. Swayze, the Supreme Court of Canada ruled that "[t]he right to refuse unwanted medical treatment is fundamental to a person's dignity and autonomy. This right is equally important in the context of treatment for mental illness."*

1 (1990), 67 D.L.R. (4th) 321 (Ont. C.A.).

2 *Ibid* at para. 328.

3 2003 SCC 32.

4 *Ibid* at para. 75.

5 *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181 [*Health Care (Consent) and Care Facility (Admission) Act*], s. 5.

6 *Ibid*, s. 3; *Representation Agreement Act*, R.S.B.C. 1996, c. 405 [*Representation Agreement Act*], s. 3.

7 *Health Care (Consent) and Care Facility (Admission) Act*, ss. 11, 16.

8 *Representation Agreement Act*, ss. 7, 9.



kin” because they must be chosen from a ranked list of family members or friends (eg. a spouse, an adult child, a parent, a sister or brother, a close friend). If there is no family member willing and able to make the health care decision, an employee of the Public Guardian and Trustee must make the health care decision.<sup>9</sup>

However, *Mental Health Act* detainees do not have the equal protection and equal benefit of these health care consent rights. By operation of s. 31(1) of the *Mental Health Act*, every detainee is deemed to consent to any psychiatric treatment authorized by the director. In practice the director’s power to authorize treatment is delegated to health care providers, like physicians and nurses. Deemed consent is a legal fiction, that is, the law creates the fiction that consent has already been provided, so there is no need to obtain consent from either the detainee or anyone else. Detainees are not presumed to be capable of giving, refusing, or revoking consent to psychiatric treatment. There is no statutory requirement to assess whether a detainee is capable of giving, refusing, or revoking consent to psychiatric treatment. As soon as an individual has been certified under the *Mental Health Act*, she can be forcibly administered psychiatric treatment.

Unlike other adults in BC, *Mental Health Act* detainees are denied access to planning tools, like the Representation Agreement. The *Representation Agreement Act* prohibits detainees from making a Representation Agreement authorizing a family member or friend to refuse consent to psychiatric treatment.<sup>10</sup> The *Health Care (Consent) and Care Facility (Admission) Act* also deprives detainees of the health care consent rights set out in that Act in relation to psychiatric care or treatment, including the right to make an Advance Directive and the right to have psychiatric treatment decisions made by a Temporary Substitute Decision Maker.<sup>11</sup> This means that family members and friends are excluded from participating in their loved one’s recovery process by being involved in psychiatric treatment decisions for individuals detained under the *Mental Health Act*.

The deemed consent model leads to a number of absurd results. First, since there is no requirement that detainees be assessed to establish whether they are capable of making treatment decisions, detainees who are mentally capable of making their own treatment decisions are administered treatment without their consent. Detainees who are mentally incapable of making treatment decisions are administered treatment without the consent of a supported or substitute decision maker. Canadian law requires that when health care providers propose treatment, the decision to accept or refuse the treatment is made by another person, either the patient himself or his supported or substitute decision makers. The deemed consent provision eliminates this safeguard for *Mental Health Act* detainees — the treating physician who proposes psychiatric treatment for detainees can also impose the treatment without recourse to another person.

Second, deemed consent continues to operate for *Mental Health Act* patients who are released on extended leave. As a result, individuals living in their own homes in the community and going about their daily lives are deprived of the right to make their own psychiatric treatment decisions. Representatives reported representing clients who were living in the community on extended leave and actively working as a nurse, a construction worker, and a school teacher who were still not permitted to make their own psychiatric treatment decisions through the operation of deemed consent.

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9 *Health Care (Consent) and Care Facility (Admission) Act*, s. 16.

10 *Representation Agreement Act*, s. 11(1)(b)-(c).

11 *Health Care (Consent) and Care Facility (Admission) Act*, s. 2.

While there are diverging opinions about which Canadian model is the most effective, it is widely recognized that the BC *Mental Health Act* deemed consent model does not comply with the rights guaranteed by the *Charter*.

Third, *Mental Health Act* detainees still have health care consent rights in relation to all other medical care besides their psychiatric treatment decisions. Detainees who are capable of making their own medical decisions still have the right to consent, refuse, and revoke consent to medical treatment like surgery, dialysis, chemotherapy, and medications. Detainees who are incapable of making their own medical decisions still have the right to a supported or substitute decision maker. A family member or friend makes medical decisions for a detainee who is found incapable of making a physical health care decision, but is not permitted to make psychiatric treatment decisions.

Canadian jurisdictions take many different approaches to psychiatric treatment for individuals in mental health detention, however, BC is the only jurisdiction that operates on a deemed consent model. For example, some jurisdictions establish that to be certified a patient must be assessed as incapable of making psychiatric treatment decisions.<sup>12</sup> Other jurisdictions mandate that certified patients must be assessed and their right to make psychiatric treatment decisions must be respected if they are capable of making that decision.<sup>13</sup> Finally, still others require assessments for certified patients and protect certified patients' health care consent rights unless an override on a treatment decision is authorized by a court or tribunal.<sup>14</sup>

While there are diverging opinions about which Canadian model is the most effective, it is widely recognized that the BC *Mental Health Act* deemed consent model does not comply with the rights guaranteed by the *Charter*.<sup>15</sup> Section 7 of the *Charter* guarantees everyone the right to life, liberty, and security of the person and those rights may only be deprived in accordance with the principles of fundamental justice. Forced psychiatric treatment inherently involves deprivations of life, liberty, and security of the person and the deemed consent model establishes no due process to ensure that these deprivations accord with the principles of fundamental justice. Section 15 of the *Charter* guarantees everyone equality before and under the law and the right to the equal protection and equal benefit of the law without discrimination based on mental or physical disability. The deemed consent model creates a distinction between mental and physical disability and deprives individuals with mental disabilities of the equal protection and equal benefit of health care consent rights all other adults are entitled to.

As early as 1991 Canadian courts have found that laws that permit forced psychiatric treatment of individuals in mental health detention violate *Charter* rights. In *Fleming v. Reid*,<sup>16</sup> the Ontario Court of Appeal struck down legislation that permitted a tribunal to override the decision of a substitute decision maker and order forced psychiatric treatment as a violation of the s. 7 *Charter* right to security of the person. In writing for the Court, Robins J.A. concluded as follows:

12 See Nova Scotia for example, *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42, s. 17.

13 See Ontario for example, *Mental Health Act*, R.S.O. 1990, c. M-7 and *Health Care Consent Act*, 1996, S.O. 1996, c. 2.

14 See Alberta for example, *Mental Health Act*, R.S.A. 2000, c. M-13, s. 29.

15 For a discussion on these opinions, see Sophie Nunnelle, "Involuntary Hospitalization and Treatment: Themes and Controversies", in Jennifer A. Chandler & Colleen M. Flood, eds., *Law and Mind: Mental Health Law and Policy in Canada* (Toronto: LexisNexis, 2016) 113.

16 [1991] 4 O.R. (3d) 74 (Ont. C.A.).

*The right to determine what shall, or shall not, be done with one's own body, and to be free from non-consensual medical treatment, is a right deeply rooted in our common law. This right underlies the doctrine of informed consent. With very limited exceptions, every person's body is considered inviolate, and, accordingly, every competent adult has the right to be free from unwanted medical treatment. The fact that serious risks or consequences may result from a refusal of medical treatment does not vitiate the right of medical self-determination. The doctrine of informed consent ensures the freedom of individuals to make choices about their medical care. It is the patient, not the doctor, who ultimately must decide if treatment -- any treatment -- is to be administered.*

...

*Few medical procedures can be more intrusive than the forcible injection of powerful mind-altering drugs which are often accompanied by severe and sometimes irreversible adverse side effects. To deprive involuntary patients of any right to make competent decisions with respect to such treatment when they become incompetent, and force them to submit to such medication, against their competent wishes and without the consent of their legally appointed substitute decision-makers, clearly infringes their Charter right to security of the person.*

The BC model of deemed consent currently has even fewer consent rights and due process than the Ontario legislation that was struck down in 1991 — the BC legislation denies detainees the right to a substitute decision maker and has no tribunal process as a safeguard to authorize forced psychiatric treatment. It is clear that a court would find the deemed consent model violates the rights guaranteed by the *Charter*. However, it is very challenging for *Mental Health Act* detainees who are experiencing or have experienced forced psychiatric treatment to initiate and sustain a law suit to strike down the legislation.<sup>17</sup> In a comparative analysis of Canadian mental health detention legislation, Simon Verdun-Jones and Michelle Lawrence conclude that it is doubtful the BC *Mental Health Act* would survive a constitutional challenge, but articulate the barriers that exist for detainees to launch such a challenge:

*It is surprising, given the pronouncements of the courts with respect to the significance of the right to refuse medical treatment and the seriousness of the consequence at stake in the mental-health context, that the Legislature of British Columbia would allow for deemed consent in such circumstances. The provisions of its Mental Health Act operate so as to deny mental-health patients — including those who are otherwise competent to make informed decisions as to health care — the right to refuse treatment to which they might well object on reasonable and rational grounds.*

*Perhaps more surprising, and more disappointing, is the fact that this provision has yet to be tested in the courts. Of course, it is doubtful that potential plaintiffs have ready access to legal representation, or the opportunity to obtain injunctive relief in the short space of time between the formulation of a treatment decision by the director of the medical-health facility and the administration of antipsychotic medication on the patient. It is questionable whether the patient would be similarly motivated-or practically able-to launch post facto proceedings.<sup>18</sup>*

The BC Government has been aware that the deemed consent model is not constitutionally compliant for over a quarter of a century and has been repeatedly called on to review and amend the deemed consent model. In the 1994 *Listening* report, the Ombudsperson expressed concern that for patients who disagree

17 At the time this report is written, there is a pending *Charter* challenge to the deemed consent model: *MacLaren, D.C., and the Council of Canadians with Disabilities v. Attorney General of British Columbia*, Notice of Civil Claim, Vancouver Registry, No. S-168364 (B.C.S.C.).

18 Simon N. Verdun-Jones and Michelle S. Lawrence, "The Charter Right to Refuse Psychiatric Treatment: A Comparative Analysis of the Laws of Ontario and British Columbia Concerning the Right of Mental-Health Patients to Refuse Psychiatric Treatment" (2013) 46:2 UBC L. R. 489 at 522.

with their treatment, “British Columbia provides significantly fewer substantive and procedural rights to patients than is the case in several other provinces” and urged the Ministry of Health to review and amend the law to introduce procedural fairness mechanisms for psychiatric treatment decisions.<sup>19</sup> The report went on to consider the prohibition on detainees using planning tools available to everyone else in BC and concluded as follows:

*the Representation Agreement Act empowers individuals to plan for their health care needs during a future period of incapacity. The idea that the power to plan is available to everyone, except the person who later becomes involuntarily detained by reason of mental disorder, seems odd. In fact, it appears, on its face, to be discriminatory and to be a denial of the equal benefit of the law... Pre-planning for episodes of mental illness is something to encourage, both because it respects the dignity and autonomy of the individual, and because it may often result in more appropriate treatment.<sup>20</sup>*

In the 2006 report *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, the Standing Senate Committee on Social Affairs, Science and Technology found that making a legal plan through advance directives or appointing substitute decision makers would ensure family access to personal health information while also preserving the autonomy and dignity of persons living with mental illness.<sup>21</sup> The Committee recommended:

- *That all provinces and territories empower mentally capable persons, through legislation, to appoint substitute decision makers and to give advance directives regarding access to their personal health information.*
- *That provisions in any provincial legislation that have the effect of barring persons from giving advance directives regarding mental health treatment decisions be repealed.*
- *That all provinces and territories make available forms and information kits explaining how to appoint substitute decision makers and make advance directives.*
- *That all provinces and territories make available community-based legal services to assist individuals in appointing substitute decision makers and making advance directives.*
- *That all provinces and territories undertake public education campaigns to educate persons with mental illness, and their families, about the right to appoint a substitute decision maker and make an advance directive.<sup>22</sup>*

*[Emphasis added.]*

There are also significant concerns that the BC *Mental Health Act* does not comply with international human rights law. Article 12 of the UN CRPD reaffirms that persons with disabilities have the right to legal capacity on an equal basis with others in all aspects of their lives. The UN CRPD requires state parties to provide for appropriate and effective safeguards to ensure that measures relating to exercising legal capacity respect the rights, will and preferences of the person, are free from conflict of interest and undue influence, are proportional and tailored to the person’s circumstances, apply for the shortest time possible; and are subject to regular review by a competent, independent authority or judicial body.

19 British Columbia, Office of the Ombudsperson, *Listening: A Review of Riverview Hospital*, Public Report No. 33 (May 1994), online: <<https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2033%20Listening%20A%20review%20of%20Riverview%20Hospital.pdf>> [Listening] at 4-10 to 4-12.

20 *Ibid* at 4-18.

21 Senate, Standing Senate Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services In Canada* (May 2006) at 70 (Chair: Michael J.L. Kirby).

22 *Ibid* at 70-71.

In *Equality, Dignity and Inclusion*,<sup>23</sup> Froese found that BC fails to fulfill the UN CRPD requirements in many respects. BC legislation does not explicitly recognize a detainee's right to be presumed capable.<sup>24</sup> The *Mental Health Act* does not establish a process or set out clear and objective criteria to assess a detainee's capacity to make decisions, but instead deprives detainees of the right to exercise their capacity simply because they have a mental illness.<sup>25</sup> The overrides in BC legislation prohibit, rather than promote, access to Advance Directives and Representation Agreements.<sup>26</sup> The *Mental Health Act* does not recognize that persons living with a mental illness may require support to exercise their legal capacity or establish a mechanism to enable a supported decision-making process.<sup>27</sup> Finally, the legislation does not establish any substitute decision making process or any independent review process.<sup>28</sup>

This section will begin by discussing what psychiatric treatment consists of for *Mental Health Act* detainees and the impacts of the unusual BC deemed consent model. The section will then turn to consider the issue of how psychiatric treatment is documented and authorized for detainees in the regulatory Form 5—Consent for Treatment (Involuntary Patient). The section will conclude with a discussion on second medical opinions, which have several significant shortcomings in providing effective oversight of forced psychiatric treatment.

## PSYCHIATRIC TREATMENT AND DEEMED CONSENT TO TREATMENT

### REPRESENTATIVES REPORTED

When asked what psychiatric treatment consisted of for the detainees they represented, all the representatives reported that treatment entailed administration of psychotropic pharmaceutical agents. These agents alter chemical levels in the brain that affect mood, thinking, and behaviour and can be ingested orally, injected intramuscularly, or, rarely, administered intravenously. One representative explained that the issue from the treating psychiatrists' perspectives in getting a patient from involuntary to voluntary status is almost exclusively focused on whether the patient will take medications. Some representatives also reported that they had represented detainees who had been forced to undergo Electroconvulsive Therapy. Electroconvulsive Therapy, which is also known as electroshock therapy, is a psychiatric treatment in which seizures are induced by administering electric currents through electrodes placed on the patient's head. It is generally administered to patients under general anesthetic.

Several representatives reported that when isolation or seclusion (solitary confinement in a small, locked room) is used with detainees, it is often unclear whether it is a disciplinary measure, a tactic to induce compliance with treatment, or a treatment method in and of itself. Some representatives reported that they had seen placement in seclusion recorded as a type of treatment on Form 5s, which will be discussed in more detail in the following section. One representative expressed significant concern about a client who had been kept in solitary confinement for several days, which the treating physician testified at the review panel hearing was a treatment method. There is overwhelming evidence that there is no therapeutic

23 British Columbia, *Equality, Dignity and Inclusion: An Evaluation of British Columbia's Mental Health Laws, Policies and Service Standards*, by Beverly Froese, in Report to the Law Foundation of British Columbia (Victoria: 31 March 2017).

24 *Ibid* at 23.

25 *Ibid* at 24.

26 *Ibid* at 28.

27 *Ibid* at 30.

28 *Ibid* at 31.

value to seclusion and that the sensory deprivation and lack of human contact have demonstrated and significant harms to an individual's mental health.<sup>29</sup>

Other representatives explained that detainees were sometimes put in seclusion for failing to cooperate with treatment and told that they would not be let out of seclusion until they agreed to cooperate with treatment. One representative explained seeing notes in medical records to the effect of: 'patient did not want to take pill, so I told him that if he didn't we would call security, put him in seclusion, and inject him'. Forced injections can involve a great deal of physical force and once detainees have had the experience of being pinned face down to their beds by private security guards with their pants and underwear removed and a needle injected into their gluteus, they often capitulate to taking pills when faced with the threat of such force again. Forced administration of treatment can also overlap with a disciplinary measure, staff convenience, or behaviour modification tactic. For example, some representatives said that it is common for detainees to become upset and agitated when faced with forced administration of pharmaceutical agents and try to express opposition to the treatment. The use of seclusion is discussed in more detail in section 2 | **Restraints and Seclusion**.

Representatives reported that detainees they had represented asked for access to therapeutic activities as alternatives to or in tandem with psychotropic pharmaceutical agents, such as counselling, cognitive behavioural therapy, group therapies, addictions treatment, anger management programs, nutrition based or naturopathic remedies, music therapy, art therapy, medical marijuana, exercise, yoga, meditation or mindfulness, and going outside for fresh air. Representatives who had contact with detainees who had requested alternative treatments from their treating psychiatrists reported that access to alternatives was largely ignored or not facilitated. Others had observed facility staff deny or interfere with access to alternative treatments, such as not permitting detainees to use cognitive behavioural therapy relaxation techniques that conflicted with ward schedules or not permitting detainees to bring in a yoga mat from home. A few representatives had observed that some detaining facilities offer some of these therapeutic activities, such as Hearing Voices Network support groups, but that access varied greatly across facilities. Representatives with experience representing clients in civil and forensic mental health detention reported that access to alternative treatments was much better in the forensic system than the civil mental health system.

By far the most common treatment request that representatives reported *Mental Health Act* detainees make is for counselling or some form of talk therapy. The majority of representatives reported that detainees often express that they want counselling to address mental health symptoms they were experiencing as a result of traumatic experiences in their life. Representatives reported that counselling is typically not available to inpatient detainees and explained that when a detainee meets with their treating psychiatrist, it is usually an interview or check in for the purposes of information gathering, rather than a conversation with any therapeutic purpose. One representative described the purpose of conversations between detainees and their treating psychiatrists as "getting updates" and "are you complying with medications". Some representatives stated that even if treating psychiatrists offered counselling, many detainees would not feel comfortable speaking freely with them because of the significant power imbalance and the fear that anything they say could be documented and support prolonged detention or more forced psychiatric treatment. A few representatives specifically raised the issue that women who had experienced sexual violence often want peer based counselling or the support of women's groups. One representative

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29 British Columbia Ministry of Health, "Provincial Quality, Health and Safety Standards and Guidelines for Secure Rooms in Designated Mental Health Facilities under the B.C. Mental Health Act (June 2014), online: <<https://www.interiorhealth.ca/AboutUs/BusinessCentre/Construction/Documents/Provincial%20standards%20and%20guidelines%20for%20secure%20rooms.pdf>> at 25.



## IN THE WORDS OF THE LEGAL REPRESENTATIVES:

**“The state feels a responsibility to take care of somebody, but they’re not really in it all the way... It’s paternalistic, but it’s more than that, it’s like an abdication of their responsibility ... They basically abdicate to the medical profession, but I don’t think they give the medical profession all the tools that are available...”**

expressed concern that in BC we are currently warehousing people on a long-term basis without offering counselling or other treatment initiatives to support recovery.

*“The tension in the Mental Health Act ... there’s confusion around what is the purpose of the Mental Health Act. I think this is the essence of the tension between the Charter and the Act — and that’s the parens patriae approach. The state feels a responsibility to take care of somebody, but they’re not really in it all the way... if they were in it all the way, they would open it up to have different treatment modalities offered ... It’s paternalistic, but it’s more than that, it’s like an abdication of their responsibility ... They basically abdicate to the medical profession, but I don’t think they give the medical profession all the tools that are available because those other treatment options, they’re costly ... because it requires space, it requires supervision, it requires enough staff that are able to provide support, supervision, monitoring, without resorting to seclusion, without resorting to physical restraints ... treatment settings that are culturally sensitive, gender sensitive, age sensitive. And so that all costs money.”*

Some representatives reported that detainees on extended leave in the community generally get access to more resources and treatment alternatives than inpatient detainees. For instance, a few representatives commented that the relationship a detainee has with a social worker or case worker with a mental health team can often be quite valuable because the detainee feels listened to by the social worker or case worker. Representatives reported that some detainees on extended leave can access counsellors if they can afford to pay for counselling. Representatives had observed some detainees on extended leave obtain access to free counselling or occupational therapy, although they noted that there were often wait lists for such resources. A few representatives raised concerns that they had observed mental health teams refuse to continue providing services to patients who want to continue with treatment plans following a review panel decision to discontinue detention.

Regardless of whether the deemed consent to treatment model in operation in BC is legally, clinically, or ethically justifiable or effective, representatives reported that forced psychiatric treatment has a significant impact on detainees. Some representatives reported that they had represented detainees who left BC simply to avoid the operation of the deemed consent treatment model.

*“It’s not their health care treatment, it’s something that’s imposed on them.”*

*“They want to make their own treatment decisions. They don’t want a doctor to do trial and error with them with different medications. They tend to feel like guinea pigs or experiments or something like that.”*

*“They are sometimes scared of the treatments.”*

## IN THE WORDS OF THE LEGAL REPRESENTATIVES:

*“My clients, the majority of them, of course, feel like their independence is taken away. It’s very disheartening to them. It causes them... increased anxiety, it can lead to depression-like symptoms. And in some of these cases, they’ll explain this to the doctor and the doctor will write down that it’s a part of their primary illness and so it’s just cyclic. Nothing seems to be addressed.”*

*“The frustration, the not being heard, it compounds their feelings, I think, of powerlessness. This is all external and happening to me.”*

*“The patronizing role of the doctor sometimes can negatively impact the development of therapeutic rapport. It can impact the development of a treatment program that works for the client. Those two things I think would contribute... to non-compliance rates...”*

*“My clients, the majority of them, of course, feel like their independence is taken away. It’s very disheartening to them. It causes them... increased anxiety, it can lead to depression-like symptoms. And in some of these cases, they’ll explain this to the doctor and the doctor will write down that it’s a part of their primary illness and so it’s just cyclic. Nothing seems to be addressed.”*

*“You feel stripped of your control of the situation, the ability to participate, the ability to know what’s going on, the ability to feel like you, you know, just basic human dignity, in terms of having some ability to control or even know what’s happening to you.”*

*“They feel like they’re not in control of their body... I’ve seen women who’ve been abused in the past telling me this is really triggering of those moments when other people had control over them. You remove their free will, you are infantilizing them.”*

Several representatives pointed out that removing agency and autonomy can account for some detainees’ resistance to treatment. These representatives were of the view that making your own decisions, even if they are the same as what would have been involuntarily imposed on you can be empowering.

*“It has been less that they don’t want to take the medications, more that they want the autonomy of deciding about the medications.”*

*“Most people... felt like they had lost their autonomy in terms of not being able to make these decisions. One person on extended leave... his big thing was that he was willing to come to treatment and wanted to continue everything just the way it was but he wanted it to be his choice because he thought that would be powerful in his recovery.”*

*“I had a client a while ago... he liked his psychiatrist, thought the medication was great, had been seeing him for quite some time, had a good relationship, was planning on continuing with the mental health team, liked his case manager... often times when someone goes to a review panel like that, the question asked is, “So, if you’re not going to change anything, why are we here? If you agree with everything, why does it matter?” And I said, “So if that was posed to you, how do you feel about that — what’s your answer?” He said, “You know, being certified under the Mental Health Act, for me, feels like I’m wearing a coat that’s two sizes too small. It’s always there... it’s always on me... and that was somebody who found the establishment, for lack of a better term, was helpful for him.”*

Several representatives reported the majority of detainees and their family members and friends who have concerns about treatment do not object to all psychiatric treatment, but to a specific form of treatment. For example, some representatives explained that they had represented clients who said they would agree to any form of treatment except for Electroconvulsive Therapy. Others reported that they had spoken with detainees and their family members and friends who objected to the specific psychotropic pharmaceutical agent administered because they knew from past experience that a different agent or a different dosage had worked better for them. One representative gave the example of an elderly client with depression who had sought out treatment in hospital. She had made a Representation Agreement to appoint her granddaughter as her representative and made her treatment wishes clear: she was willing to take any medication and engage in any kind of treatment except Electroconvulsive Therapy. When she would not consent to Electroconvulsive Therapy proposed to her in hospital, her treating psychiatrist detained her pursuant to the *Mental Health Act* so that he could override her refusal and the refusal of her Representative authorized in her Representation Agreement.

Several representatives reported that the concerns of detainees and their family and friends about the efficacy or side effects of medications were often not taken seriously and that they had no way to challenge the course of treatment. One representative gave the example of representing a detainee who had been injected with a psychotropic pharmaceutical agent that she was allergic to, despite the fact that she had a note from her family physician documenting her allergy. It was not until she developed welts at her injection site that the treating physician believed her and listened to her objections. Another representative gave an example of representing a detainee on extended leave who had gained a significant amount of weight as a side effect to a psychotropic pharmaceutical agent. Her psychiatrist refused to adjust the dosage or try a different agent when she told him that her clothes did not fit, she did not want to go out any longer, and the treatment was negatively affecting her health and self-esteem. As a result, detainees sometimes apply for review panels not because they want to leave facilities, but simply because decertification is the only mechanism to regain the right to make psychiatric treatment decisions.

*"Patients are not treated seriously when they report having side effects or bad reactions to the medications."*

*"Most of my conversations with clients revolve around side effect of drugs and how they feel as though they're not listened to about the side effects of drugs. And I feel that that directly deteriorates their relationship with the physician."*

*"There were some clients I had who had, genuinely believed they had a mental disorder and didn't necessarily disagree with the diagnosis, but just felt completely cut off because of their involuntary status... I don't think it helped create like, a good therapeutic relationship with the psychiatrist. I think they viewed them more as an adversary because they weren't able to have any input on their treatment... If they talked about side effects or suggested some other forms of treatment, it was almost held against them in terms of certification..."*

*"Sometimes it would come out at the hearing, and this isn't really the exact purpose of the hearing, but someone would express that they had certain side effects with medication and one of their frustrations was that they didn't feel like their concerns were being listened to... Even if their detention continued after the hearing, they had told me that being able to express this, some of their concerns about their treatment program, they got a little bit more traction with the doctor and... the doctor was willing to listen to that conversation and adjust things or to take other options into consideration."*

## CONCLUSION AND RECOMMENDATIONS

BC's deemed consent model permits treating physicians to make psychiatric treatment decisions unilaterally, without assessing whether a detainee is capable of making his own treatment decisions and without recourse to any other decision maker. Representatives reported many negative impacts of forced psychiatric treatment, including increased feelings of helplessness and fear, failure to involve individuals in an autonomous and collaborative recovery plan, adversarial relationships with mental health care professionals, avoidance of voluntary mental health services, and minimization and disregard of reported experiences and side effects with psychiatric treatment. The exclusion of family members and friends from psychiatric treatment decisions contributes to the isolation of individuals with mental disabilities and discounts the valuable role that personal support networks play in recovery. The prohibition on *Mental Health Act* detainees using planning tools like Representation Agreements means individuals with mental health problems are not permitted to put a legal plan in place to prevent or ameliorate future mental health crises. BC is the only deemed consent model of psychiatric treatment in Canada and while there are diverging opinions about which model is the most effective, it is widely recognized that the BC deemed consent model does not comply with the rights guaranteed by the *Charter* and the UN CRPD.

The **BC Government** should review and amend the current deemed consent to psychiatric treatment model contained in the *Mental Health Act*, *Health Care (Consent) and Care Facility (Admission) Act*, and the *Representation Agreement Act*. Amendments must establish equal health care consent rights for physical and mental health care decisions, including as a minimum,

- The right to be presumed capable and the right to an assessment to establish whether *Mental Health Act* detainees are capable of making psychiatric treatment decisions;
- The right to make psychiatric treatment decisions for *Mental Health Act* detainees who are assessed as capable of making psychiatric treatment decisions;
- The right to have a supported or substitute decision maker make psychiatric treatment decisions for *Mental Health Act* detainees who are incapable of making psychiatric treatment decisions; and
- A fair and independent process for *Mental Health Act* detainees to challenge the outcome of a capacity assessment and any forced psychiatric treatment.

### SUMMARY OF RECOMMENDATIONS

#### PSYCHIATRIC TREATMENT AND DEEMED CONSENT

For the BC Government:

- Review and amend the deemed consent model to establish equal health care consent rights for physical and mental health care decisions.

## DOCUMENTING AND AUTHORIZING PSYCHIATRIC TREATMENT ADMINISTERED

As discussed in the overview, s. 31 of the *Mental Health Act* eliminates the requirement for health care providers to obtain consent for psychiatric treatment by creating the legal fiction that all detainees are deemed to consent to all psychiatric treatment. Form 5—Consent for Treatment (Involuntary Patient) is a regulatory form in which the treatment or course of treatment that will be provided to a particular detainee is documented. The Form 5 states that the nature of the condition, options for treatment, and the reasons for and the likely benefits and risks of the treatment described on the form have been explained to the detainee.

Form 5 is extremely confusing for a number of reasons. First, there is no requirement in either the *Mental Health Act* or *Mental Health Regulation* that Form 5 be completed before medical treatment can be administered. Its existence among the regulatory forms implies that it should be completed and the *Guide to the Mental Health Act* opines that Form 5 must be completed prior to the administration of medical treatment to avoid legal liability. However, the statute and regulations provide no explicit requirements for when the Form 5 should be completed and how frequently it should be renewed.

Second, there is no requirement in either the *Mental Health Act* or *Mental Health Regulation* that detainees be assessed to establish whether they are capable of making treatment decisions. Form 5, however, presents a confusing and contradictory message in its signature sections. Section A may be signed by the detainee, in which case the treating physician signs the Form 5 to indicate that the detainee was capable of understanding the nature of the above authorization at the time it was signed. Section B may be signed by the director or a delegate of the director (for example, a nurse or a physician), in which case the treating physician signs the Form 5 to indicate that the detainee was incapable of appreciating the nature of the treatment and/or his or her need for it, and is therefore incapable of giving consent. The format of the Form 5 signature lines conflates mental capacity to make a treatment decision with agreement to proposed treatment. There is no option for a detainee who is capable of understanding the nature of the treatment to refuse some or all of the treatment or request different treatment. There is no option for a detainee's supported or substitute decision maker to consent to or refuse some or all of the treatment or request different treatment.

Third, there is no clarity in the *Mental Health Act* or *Mental Health Regulation* regarding who should sign section B of Form 5. The *Guide to the Mental Health Act* states that it is "strongly recommended that wherever possible, the person signing Form 5 as the director or designate should be someone other than the treating physician."<sup>30</sup> Although this is not a requirement in the statute or regulations, this recommendation is likely made to try to attenuate the risks inherent in psychiatric treatment being proposed and administered by the treating physician without another individual involved in making treatment decisions.

Fourth, there is no time limit on the Form 5 or requirement to revisit the treatment documented in the form or the detainee's capacity or willingness to consent to proposed treatment at any point in time. One Form 5 is typically completed when an individual is initially detained and is relied on for authorization to provide treatment for the entire length of an individual's detention. As discussed in section 1 | **Detention Decisions**, an individual can be subject to involuntary status pursuant to the *Mental Health Act* indefinitely,

30 British Columbia, Ministry of Health, *Guide to the Mental Health Act*, 2005 edition (4 April 2005), online: <<http://www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf>> at 19.

Given that the purpose, function, and authority of the Form 5 are unclear in law, it is unsurprising that there is a great deal of misunderstanding among health care providers of how to complete the Form 5. However, the Form 5 should at least function as a record for detainees to refer to of what psychiatric treatment they were administered during their detention.

either as an inpatient or living in the community through the extended leave provisions. As a result, an individual could be living in her own home, going to work, and going about all other aspects of her daily life but still be subject to forced psychiatric treatment described and authorized on a Form 5 completed several years ago.

In the *Listening* report the Ombudsperson criticized the lack of procedural fairness involved in completing a Form 5, pointing out that “British Columbia provides significantly fewer substantive and procedural rights to patients than is the case in several other provinces”.<sup>31</sup> The report concluded that “it is inherently unfair for a system to permit individuals who are competent to decide whether or not to receive psychiatric treatment to be stripped of the power to make that decision by a purely administrative act (the hospital director’s signing of a form)” and urged the BC Government to reform the *Mental Health Act* to introduce procedural fairness into decision-making concerning the provision of psychiatric services and independent review of psychiatric treatment decisions.<sup>32</sup>

Given that the purpose, function, and authority of the Form 5 are unclear in law, it is unsurprising that there is a great deal of misunderstanding among health care providers of how to complete the Form 5.<sup>33</sup> However, the Form 5 should at least function as a record for detainees to refer to of what psychiatric treatment they were administered during their detention.

The level of documentation on Form 5s is generally so poor that representatives could not tell from reading the Form 5 what psychiatric treatment was administered.

## REPRESENTATIVES REPORTED

All the representatives with observations regarding Form 5s reported that the level of documentation on Form 5s was generally so poor that they could not tell from reading the Form 5 what psychiatric treatment was administered. As with many other areas in the mental health detention system, representatives observed a great deal of variety among and within facilities in how Form 5s were completed. Several representatives reported that they had encountered records in which the Form 5 was missing or signed on the chart completely blank with no form of treatment documented. Two representatives reported that the Form 5s were almost always completed with hand writing and

<sup>31</sup> *Listening* at 4-10.

<sup>32</sup> *Ibid* at 4-11 to 4-12.

<sup>33</sup> For example, this was documented in interviews with health care providers in Iva Cheung, *Increasing understanding of the British Columbia Mental Health Act: preliminary work* (September 2016) [unpublished] at 20.



Two representatives stated that health care providers treated Form 5s like “a joke” and one representative described Form 5 as “a useless piece of paper with a signature on it”.

they often could not read what had been written. Two representatives stated that health care providers treated Form 5s like “a joke” and one representative described Form 5 as “a useless piece of paper with a signature on it”.

When Form 5s are present in a detainee’s records, completed, and legible, representatives reported that the treatment was documented in such generic and vague terms that it provided no functional assistance to understanding what treatment was administered for a particular detainee. For instance, the treatment was described using generic words like “hospitalization”, “medications”, “psychopharmacology”, “treatment”, “assessment”, “investigations”, “observation”, “seclusion”, and “restraint”. Some facilities have developed a stamp that they use on all detainees’ Form 5s that states something generic, such as “PSYCHIATRIC ASSESSMENT AND TREATMENT AS RECOMMENDED BY THE ATTENDING PHYSICIAN”. Other facilities print Form 5s with a standardized typed sentence that simply repeats that any psychiatric treatment may be administered pursuant to the deemed consent provision of the *Mental Health Act*. Some of these typed sentences mistakenly reference s. 21 as the deemed consent provision, rather than s. 31.

Most representatives reported that they had never seen a Form 5 in which a detainee signed section A to indicate that she would agree to treatment. Others reported that they had only seen a Form 5 in which a detainee signed section A “once” or “very rarely”. One representative stated that in over 25 years of representing clients at review panels she had only seen two Form 5s in which a detainee signed section A. Several representatives reported that it appears that treating physicians tend to simply complete the Form 5 as a matter of course after an individual is detained without speaking to the detainee about what treatment is being considered and whether he would agree to the treatment. These representatives were of the view that treating physicians often miss opportunities to involve detainees in their own treatment plans.

Finally, when asked who typically signs section B on Form 5 to authorize treatment on behalf of detainees, most representatives reported that they often could not tell who signed the Form 5 because the forms were not properly completed. When the authorizing signatory had properly completed the form, a few representatives reported that Form 5 almost always appeared to be signed by the treating physician. Others reported that it was usually a nurse who signed as a delegate of the director to authorize the physician’s treatment and only sometimes had they seen a treating physician sign. Still others reported that they had seen someone in an administrative role who was neither a physician nor a nurse sign. One representative said that in his experience the Form 5 was usually completed and signed by the emergency room physician on the first day of detention, and it was not revisited once the detainee had a treating psychiatrist after being transferred to a new ward, facility, or mental health team.

**FORM 5: Example of poorly completed Form 5s provided by representatives that do not describe the treatment authorized and administered.**

**FORM 5  
MENTAL HEALTH ACT  
(Sections 9 and 31, R.S.B.C. 1996, c. 208)  
CONSENT FOR TREATMENT  
(INVOLUNTARY PATIENT)**

Note: Complete either A or B

A. I, [redacted], authorize the treatment described below.

B. I, [redacted], authorize the treatment described below with respect to [redacted] at [redacted].

Description of treatment/course of treatment:

The nature of the condition, options for treatment, the reasons for and the likely benefits and risks of the treatment described above have been explained to me by [redacted].

Complete either A or B

A. If signed by patient

patient's signature [redacted]  
date signed (dd / mm / yyyy) [redacted] time [redacted]

witness signature [redacted]  
witness first and last name (please print) [redacted]

To the best of my judgment, the above-named patient was capable of understanding the nature of the above authorization at the time it was signed.

signature of physician [redacted], M.D.

HC7-1001 Rev. 2003/01/01

**FORM 5  
MENTAL HEALTH ACT  
(Sections 9 and 31, R.S.B.C. 1996, c. 208)  
CONSENT FOR TREATMENT  
(INVOLUNTARY PATIENT)**

Note: Complete either A or B

A. I, [redacted], authorize the treatment described below.

B. I, [redacted], authorize the treatment described below with respect to [redacted] at [redacted].

Description of treatment/course of treatment: *Pharmaco therapy*

The nature of the condition, options for treatment, the reasons for and the likely benefits and risks of the treatment described above have been explained to me by [redacted].

Complete either A or B

A. If signed by patient

patient's signature [redacted]  
date signed (dd / mm / yyyy) [redacted] time [redacted]

witness signature [redacted]  
witness first and last name (please print) [redacted]

To the best of my judgment, the above-named patient was capable of understanding the nature of the above authorization at the time it was signed.

signature of physician [redacted], M.D.

HC7-1001 Rev. 2003/01/01

**FORM 5  
MENTAL HEALTH ACT  
(Sections 9 and 31, R.S.B.C. 1996, c. 208)  
CONSENT FOR TREATMENT  
(INVOLUNTARY PATIENT)**

Note: Complete either A or B

A. I, [redacted], authorize the treatment described below.

B. I, [redacted], authorize the treatment described below with respect to [redacted] at [redacted].

Description of treatment/course of treatment:

**- HOSPITALIZATION**  
**- INVESTIGATIONS**  
**- MEDICATIONS**  
**- TREATMENT**

The nature of the condition, options for treatment, the reasons for and the likely benefits and risks of the treatment described above have been explained to me by [redacted].

Complete either A or B

A. If signed by patient

patient's signature [redacted]  
date signed (dd / mm / yyyy) [redacted] time [redacted]

witness signature [redacted]  
witness first and last name (please print) [redacted]

To the best of my judgment, the above-named patient was capable of understanding the nature of the above authorization at the time it was signed.

signature of physician [redacted], M.D.

HC7-1001 Rev. 2003/01/01

**FORM 5  
MENTAL HEALTH ACT  
(Sections 9 and 31, R.S.B.C. 1996, c. 208)  
CONSENT FOR TREATMENT  
(INVOLUNTARY PATIENT)**

Note: Complete either A or B

A. I, [redacted], authorize the treatment described below.

B. I, [redacted], authorize the treatment described below with respect to [redacted] at [redacted].

Description of treatment/course of treatment:

**Psychiatric Assessment & Treatment as Recommended by the Attending Physician**

The nature of the condition, options for treatment, the reasons for and the likely benefits and risks of the treatment described above have been explained to me by [redacted].

Complete either A or B

A. If signed by patient

patient's signature [redacted]  
date signed (dd / mm / yyyy) [redacted] time [redacted]

witness signature [redacted]  
witness first and last name (please print) [redacted]

To the best of my judgment, the above-named patient was capable of understanding the nature of the above authorization at the time it was signed.

signature of physician [redacted], M.D.

HC7-1001 Rev. 2003/01/01

## SUMMARY OF RECOMMENDATIONS

### DOCUMENTING TREATMENT

For the BC Government:

- Review and amend the *Mental Health Act* and *Mental Health Regulation* regarding documentation and authorization of psychiatric treatment.

For the Ministries of Health and Mental Health and Addictions in conjunction with the health authorities:

- Create standardized provincial policies and training regarding documentation and authorization of psychiatric treatment to address problems such as using rubber stamps rather than documenting the psychiatric treatment administered.

## CONCLUSION AND RECOMMENDATIONS

The only clear theme emerging with respect to Form 5s is that there is no consistent practice among detaining facilities in completing these forms. Regardless of what legislative structure is in place to determine how psychiatric treatment decisions are made, Form 5s are not currently serving any useful function. There is no clear law governing when, how, or even if the Form 5 should be completed. The operation of the deemed consent provision in the *Mental Health Act* makes any assessment of capacity to make decisions and questions of consent to treatment irrelevant. The form itself conflates mental capacity to make a treatment decision with agreement to proposed treatment. The most a Form 5 can achieve is to create a record for detainees to refer to of what psychiatric treatment they were administered during their detention. However, given that health care providers document the forms of treatment administered in generic categorical labels like “treatment” and “psychopharmacology”, Form 5s are currently providing no safeguard or benefit to detainees.

As discussed previously in section 4 | [Psychiatric Treatment](#), a review of the legislated deemed consent to psychiatric treatment for *Mental Health Act* detainees is long overdue. However, even if the law continues to permit non-consensual psychiatric treatment, the **BC Government** should review and amend the *Mental Health Act* and *Mental Health Regulation* regarding documentation and authorization of psychiatric treatment. Amendments must, as a minimum, establish clear law regarding the process for authorizing non-consensual psychiatric treatment, including identification of the individual with legal authority to authorize the treatment and the duration of such authority.

Regardless of legislative reform, the **Ministries of Health and Mental Health and Addictions should work in conjunction with the health authorities** to create standardized provincial policies and training to ensure that health care providers understand the requirement to document and seek authorization for the specific psychiatric treatment provided to detainees through completing Form 5s, including completing a new Form 5 when changes are made to the course of psychiatric treatment. Policies and training must address and correct the current issues reported above, such as the widespread practice of health care providers using generic categorical labels or rubber stamps rather than documenting the psychiatric treatment provided to the detainee.

## SECOND MEDICAL OPINIONS PROVIDE INADEQUATE TREATMENT OVERSIGHT

There is no automatic oversight or review of the safety or efficacy of psychiatric treatment administered to detainees pursuant to the *Mental Health Act*. The Mental Health Review Board has no jurisdiction to review psychiatric treatment. Detainees have no legal mechanism to challenge psychiatric treatment administered to them against their will. The only option available to a detainee who is unhappy with the psychiatric treatment administered to him is to request a second medical opinion on the appropriateness of the treatment.<sup>34</sup> A detainee is entitled to request a second opinion once in each certification period. The second medical opinion is provided to the director, who “must consider whether changes should be made in the authorized treatment for the patient and authorize changes the director considers should be made.”<sup>35</sup> In practice, this role is again delegated and the second medical opinion is simply delivered to the treating physician.

When detainees make a request for a second medical opinion they can either request a specific physician or request that the director appoint a physician to complete the second medical opinion. The law is structured to ensure that physicians who are not associated with the detaining facility are able to complete second medical opinions. The *Mental Health Regulation* grants authority to physicians from outside the detaining facility to access the patient, the patient’s treatment record kept by the designated facility, and the patient’s treating physician for the purpose of providing a second medical opinion.<sup>36</sup> The regulations also contemplate that physicians may have to travel to a detaining facility to provide a second medical opinion, and sets out that the detainee may have to pay for the physician’s travel expenses.<sup>37</sup> In the debates of the Legislative Assembly that led to the 1998 amendments to the *Mental Health Act*, the government of the day repeatedly pointed to second medical opinions as a procedural safeguard for the significant exercise of power in mental health detention and involuntary psychiatric treatment.<sup>38</sup> Member of the Legislative Assembly Hawkins asked pointed questions regarding the independence of second medical opinions:

*With respect to second opinions, we want to be very clear on this section. We want to know what assurance there is in this section that it will be an independent second opinion that the person will be getting.*<sup>39</sup>

There is no time limit on how long the director can take to arrange a second medical opinion once it has been requested. The *Mental Health Regulation* states that it “must be completed as soon as reasonably practicable after the director receives the request.”<sup>40</sup> The challenged psychiatric treatment may continue while the second medical opinion is arranged. The physician completing the second medical opinion must examine the detainee, but as discussed in section 1 | **Detention Decisions**, it is unclear whether an examination requires an in-person assessment of a detainee. The second medical opinion is delivered to the director or the director’s delegates and there is no requirement that a copy be given to the detainee

34 R.S.B.C. 1996, c. 288 [*Mental Health Act*], s. 31(2). Another person, such as a family member or friend, may request a second medical opinion on the patient’s behalf.

35 *Ibid*, s. 31(3).

36 B.C. Reg. 233/99, s. 8(2).

37 *Ibid*, s. 8(4).

38 British Columbia, Legislative Assembly, *Hansard* 36<sup>th</sup> Parl., 3<sup>rd</sup> Sess., Vol. 12, No. 11 (29 July 1998) at 10688, 10691, and 10693, online: Legislative Assembly of British Columbia, <<https://www.leg.bc.ca/documents-data/debate-transcripts/36th-parliament/3rd-session/19980729pm-Hansard-v12n11>>.

39 *Ibid* at 10690.

40 *Ibid*, s. 8(1).

that requested it. If the second medical opinion differs from the course of treatment being administered to the detainee, the director or the director's delegates must consider whether changes should be made, but there is no obligation to change the course of treatment.

## REPRESENTATIVES REPORTED

Representatives reported that the length of time it takes for a detaining facility to arrange for a second medical opinion after the request is made varies widely. Representatives observed that most second medical opinions took less than a week to arrange for detainees in inpatient settings because most second medical opinions were completed by a colleague of the treating physician within the same facility. However, some representatives reported that they had clients in inpatient settings who had waited as long as 3-4 months for a second medical opinion after making the request. There were two factors that representatives identified could prolong the length of time it took to obtain a second medical opinion: if a detainee is on extended leave or if a detainee requests that a specific doctor perform the second medical opinion.

Nearly all the representatives who had experience with a client who had requested a second medical opinion reported that the challenged psychiatric treatment continued while the second medical opinion was arranged and completed. Only one representative had seen challenged psychiatric treatment suspended pending a second medical opinion once, and that was because the issue of forcing a detainee to undergo Electroconvulsive Therapy in unusual circumstances had been raised as an issue for the detaining facility's ethics committee.

All the representatives who had experience with a client who had requested a second medical opinion reported that the physicians who completed the second medical opinion were almost always on staff at the detaining facility. In the words of one representative, the second medical opinions are usually just completed by a "colleague down the hall" in the same facility. Only one representative reported that he had seen efforts made to arrange for a second medical opinion to be completed by a physician at some professional distance from the treating physician—for example, by arranging for a physician who was on staff at the detaining facility, but from a different unit or ward than the treating physician.

No representative had seen a detainee charged for the travel expenses associated with a physician traveling to the detaining facility to provide a second medical opinion. This could either be because detaining facilities are voluntarily covering the travel expenses of physicians providing second medical opinions, or because there were no travel expenses to cover. One representative reported that he had observed staff at a detaining facility threatening a detainee with the prospect of being charged travel expenses to dissuade the patient from exercising his right to a second medical opinion. Another representative reported that his client had been discouraged from requesting that a specific physician that he had a relationship with complete the second medical opinion because of the prospect of travel expenses and instead was encouraged to accept a second medical opinion from a physician on staff at the detaining facility.

Most representatives had not seen a detainee make a request for a specific physician to provide a second medical opinion. One representative commented that a lot of detainees do not have a connection with a physician outside the detaining facility. However, of the four representatives who had experience with a detainee who requested a specific physician, they all expressed concern that detaining facilities did not appear to take the necessary steps to arrange for that physician to perform the examination and provide the opinion. For instance, one representative reported that when a patient fills out the request for a second

**Nearly all the representatives who had experience with a client who had requested a second medical opinion reported that they had never seen a second medical opinion recommend a different course of treatment.**

medical opinion with a request for specific physician who was not on staff at the same facility, typically nothing happens. Another representative described that a detainee who requests a specific physician must make the arrangements for the second medical opinion herself as the detaining facility would not fulfill its responsibility to arrange the examination and opinion.

When asked whether the examination a physician performs in providing the second medical opinion involved an in-person assessment, most representatives reported that you often cannot tell from the second medical opinion whether the physician examined the detainee in person. It is unclear whether conducting an examination for a second medical opinion must involve an in-person assessment and there is no requirement to record whether an in-person assessment took place. Some representatives reported that a second medical opinion typically relied on a chart review and a conversation with the treating physician and only once or twice had they seen it involve an in-person assessment. Others reported that physicians usually perform an in-person assessment of the detainee in conducting an examination for a second medical opinion. Still others said that they had seen roughly equal numbers of physicians who rely only on a chart review and a conversation with the treating physician and physicians who also perform an in-person assessment of the detainee in providing a second medical opinion.

Nearly all the representatives who had experience with a client who had requested a second medical opinion reported that the opinion is generally not provided to detainees when it is completed. These representatives reported that sometimes detainees are told verbally what the opinion consisted of, but it is often just filed on the detainee's medical chart without the detainee being informed the opinion was completed or what its contents were. Several representatives commented that detaining facility staff treat second medical opinions like all other components of the legal forms and medical records generated in relation to detention and that detaining facility staff are generally very reluctant to provide detainees with any of their forms or records. Some representatives said that when they obtained document disclosure in preparation for a review panel, they were often the first to inform their clients that a second medical opinion had been completed and stored on their chart. One representative described the second medical opinion as an "opaque process" and once completed it "disappears into a binder at the nurse's station".

Nearly all the representatives who had experience with a client who had requested a second medical opinion reported that they had never seen a second medical opinion recommend a different course of treatment. Four representatives each reported seeing one second medical opinion recommend a different course of treatment. One reported that she had seen one second medical opinion recommend a different course of treatment when a particular pharmaceutical agent was causing a detainee severe weight gain and the physician suggested switching to a different agent, which the treating physician agreed to do. The second representative reported that the only time he saw a second medical opinion result in a change to the intended course of treatment was when the detaining facility's ethics committee refused to approve forced Electroconvulsive Therapy in unusual circumstances. The third representative reported that she had only seen one opinion recommend a different course of treatment since second medical opinions were introduced in the legislation in 1998 and it resulted in no change to the course of treatment because the



## IN THE WORDS OF THE LEGAL REPRESENTATIVES:

Representatives described second medical opinions as  
“totally ineffective” and “usually a rubber stamp process”.

treating physician disregarded it. The fourth representative similarly reported that when a second medical opinion suggested other forms of treatment the suggestions were disregarded by the treating physician.

Although representatives were not asked what their overall impression was of the efficacies of second medical opinions, many volunteered their perspectives. Several representatives raised concerns that detainees were not properly informed of, and facilitated in exercising, their right to a second medical opinion. For example, one representative in a rural community said that she had met detainees who expressed that they wanted a second opinion but did not know that they had a statutory right to make a formal request for one. Two representatives reported that they had met with detainees who never received a second medical opinion despite completing the formal request. One representative observed that the request for a second medical opinion was not looked at favourably by the treatment team and that detainees were told by detaining facility staff that there was essentially no point in obtaining a second opinion and the process was a waste of time.

In addition, several representatives expressed concern that second medical opinions were not functioning as an adequate safeguard in a system that permits unilateral forced psychiatric treatment. Representatives described second medical opinions as “totally ineffective” and “usually a rubber stamp process”.

*“I’ve tried very hard to find somebody who would give a second opinion and you know, just even talking to friendly psychiatrists that I know who are like connected to friends of mine and they’re like, nobody’s going to give you a second opinion because it’s a very small world in the world of psychiatry and that person you cross could be the person who determines your promotion or hiring a year or two years from now. They said nobody wants to do them, nobody will do them, unless the second opinion is going to be confirming the first opinion, which is what almost always happens if you ask for one and the hospital finds somebody. They’re going to find somebody who agrees with opinion number one and then you’re way worse off than if you didn’t get one in the first place. I would never ever recommend to a client that they get a second opinion unless they choose the person who’s going to give the second opinion.”*

*“Objectively, there’s no value [to second opinions]... what I tell my clients is if you have a physician in mind and you know what the physician’s opinion is, and the opinion supports your position, then ask for it... If you don’t have anybody to pick then the facility will pick one, it’ll be an in-house person, and I’ve never seen a physician go against another physician in the hospital... The key issue with second opinions is ok, what is the trend here, you know? ... We’re talking about Charter rights here... there’s a high need of protection, and so when you look at the safeguards that are in place in the Act, you have to ask the question, ok, are these adequate? Does the state take their responsibility seriously? In terms of second medical opinions, the question the state needs to ask is ... how many are there? ... Are there any barriers to getting a second medical opinion? How long does it take? Do any of the second medical opinions run contrary to the treating physician? There’s no obligation to follow... how many contradictory opinions guide treatment decisions? ... If you don’t track them, if anecdotally there are no contrary decisions, if anecdotally it takes a long time to get it, if anecdotally they’re all in-house, is this an effective safeguard? Is this Charter-proof? ... And I would say it’s not effective.”*

## CONCLUSION AND RECOMMENDATIONS

Forced psychiatric treatment is one of the most invasive state deprivations of liberty and security of the person carried out in Canada today. The *Charter* requires that significant rights deprivations are only imposed following fair procedures and that robust safeguards are in place to ensure adequate oversight. Second medical opinions are completely inadequate to operate as this safeguard. No oversight occurs unless a detainee initiates a request for a second medical opinion and there are significant barriers to detainees making these requests. There is no time limit for completing the opinion and the challenged psychiatric treatment may continue while the opinion is arranged. Since the deemed consent model treats a detainee's capability to make treatment decisions as irrelevant, the second medical opinion similarly does not encompass any review of a detainee's decision making capacity. The physicians completing the second medical opinion do not always examine the detainee in person. The opinion is often not provided to the detainee. There is insufficient effort made to arrange second medical opinions from physicians who are professionally independent from the treating physician and the detaining facility. Second medical opinions almost never differ from the course of treatment administered to detainees, and even when they do, there is no obligation on the treating physician to change the treatment.

As discussed in the previous sections, a review of the legislated deemed consent to psychiatric treatment for *Mental Health Act* detainees is long overdue. However, even if the law continues to permit non-consensual psychiatric treatment, the **BC Government** should review and amend the *Mental Health Act* and *Mental Health Regulation* to establish adequate oversight mechanisms of psychiatric treatment. Amendments must, as a minimum, provide detainees with an accessible and fair procedure to seek review of non-consensual psychiatric treatment to an independent decision maker with power to affect the course of treatment.

Regardless of legislative reform, the **Ministries of Health and Mental Health and Addictions should work in conjunction with the health authorities** to create standardized provincial policies and training to ensure that health care providers understand and respect detainees' rights to timely and independent second medical opinions. Policies and training must address and correct the current issues reported above, such as health care provider tactics to discourage detainees from exercising their right to a second medical opinion and the widespread failure to arrange second medical opinions from physicians who are professionally independent from the treating physician and the detaining facility.

### SUMMARY OF RECOMMENDATIONS

#### SECOND MEDICAL OPINIONS

For the BC Government:

- Review and amend the *Mental Health Act* and *Mental Health Regulation* to establish adequate oversight mechanisms of psychiatric treatment.

For the Ministries of Health and Mental Health and Addictions in conjunction with the health authorities:

- Create standardized provincial policies and training to ensure that health care providers understand and respect detainees' rights to timely and independent second medical opinions.

# 5 | Scheduling and Preparing for a Review Panel Hearing

## OVERVIEW

Detainees are entitled to a review panel hearing once every certification period.

Individuals who are detained under the BC *Mental Health Act* are entitled to apply for periodic review of their detention by an independent tribunal, the Mental Health Review Board.<sup>1</sup> The Mental Health Review Board schedules review panel hearings to determine whether detention should continue because the criteria for detention set out in s. 22(3)(a)(ii) and (c) of the *Mental Health Act* continues to describe the condition of the detainee.<sup>2</sup> Detainees are entitled to a review panel hearing once every certification period and the Mental Health Review Board must schedule the hearing within prescribed time periods, which can be summarized as follows:<sup>3</sup>

Certification Period	Length of Detention	Hearing Scheduled
Second period (after initial 48 hr period)	1 month	Hearing must be scheduled within 14 days after application received
Third period	1 month	Hearing must be scheduled within 14 days after application received
Fourth period	3 months	Hearing must be scheduled within 28 days after application received
Fifth period	6 months	Hearing must be scheduled within 28 days after application received, provided that 90 days have passed since the conclusion of any previous hearing
All subsequent periods	6 months	Hearing must be scheduled within 28 days after application received, provided that 90 days have passed since the conclusion of any previous hearing

<sup>1</sup> R.S.B.C. c. 288 [*Mental Health Act*], s. 25.

<sup>2</sup> *Ibid*, s. 25(2).

<sup>3</sup> *Ibid*, s. 25; B.C. Reg. 233/99 [*Mental Health Regulation*], s. 6.

**Unlike many other jurisdictions, BC does not have any automatic review panel hearings to evaluate the appropriateness of ongoing detention, but instead relies on the detainee to apply for a review. As a result, individuals can be detained indefinitely in facilities without any review of their detention.**

There are two aspects of note in this legal framework for the purposes of the discussion in this section. First, the timelines between requesting review and a review panel hearing taking place are short. While this is necessary to ensure there is a prompt review of detention as guaranteed by the *Charter*, it presents unique challenges to all involved, including the Mental Health Review Board, which must schedule the hearings, the detaining facility, which must prepare to present the state's case for detention at hearings, and the detainees and their legal representatives who must prepare to present an argument for discharge at the hearings.

Second, unlike many other jurisdictions, BC does not have any automatic review panel hearings to evaluate the appropriateness of ongoing detention, but instead relies on the detainee to apply for a review.<sup>4</sup> As a result, individuals can be detained indefinitely in facilities without any review of their detention. The one provision that does not require an active request for review from a detainee is s. 25(1.1) of the *Mental Health Act*, which states that if a patient has been on extended leave or in an approved home under s. 37 or 38 for 12 or more consecutive months and a hearing has not been requested or held within that period, the Chair of the Mental Health Review Board must review the patient's treatment record and, if satisfied from this record that there is a reasonable likelihood that the patient would be discharged following a hearing under this section, must order that a hearing under this section be held. This means that an individual can have involuntary status under the *Mental Health Act* on extended leave in the community or in a long term facility indefinitely without a review panel hearing if the Chair is not notified of their detention or chooses not to order a hearing.

This section will discuss three issues relating to scheduling and preparing for a review panel. First, the section will explore the high cancellation rate of review panel hearings and consider what role detaining facility staff play in persuading detainees to cancel their review panels. Second, the section will consider the laws and the policies of the Mental Health Review Board regarding scheduling, postponing, and cancelling review panel hearings and whether amendments to these laws and policies could improve access to justice for detainees. Finally, the section will discuss the significant challenges involved in pre-hearing disclosure and the barriers that health authorities and detaining facilities have created for detainees and their legal representatives to access medical records to prepare for review panel hearings.

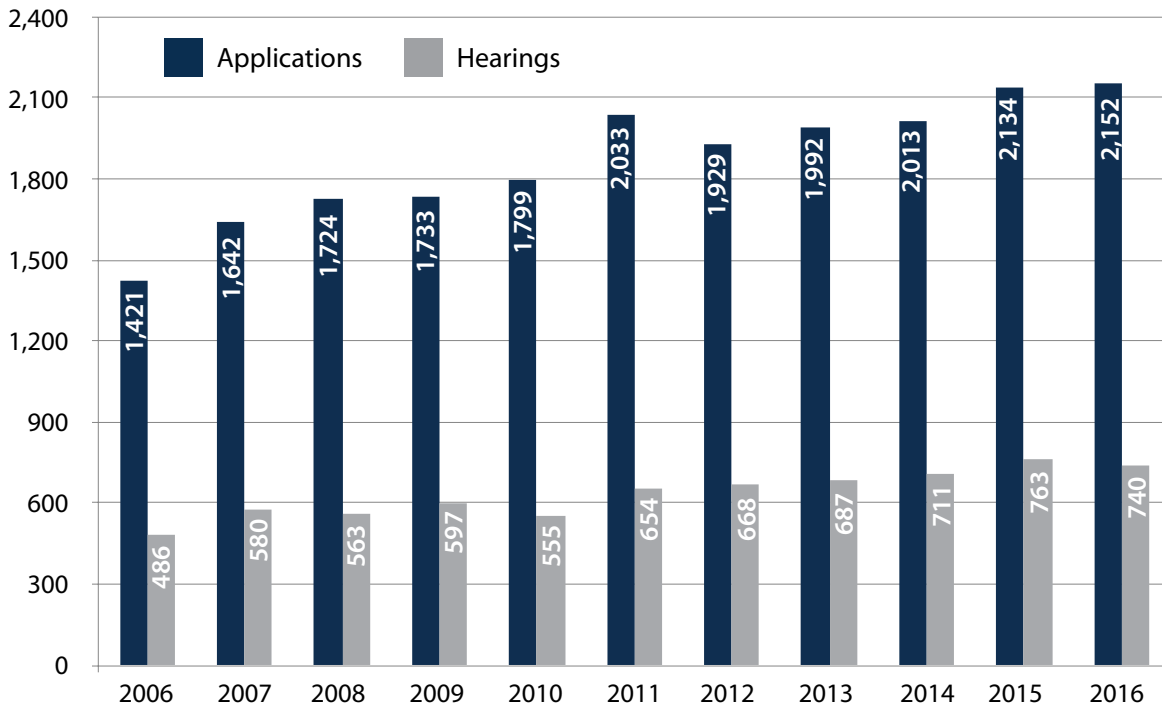
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<sup>4</sup> Another person, such as a family member or friend, can also request a review panel on the patient's behalf — see *Mental Health Act*, s. 25(1).

## DETAINING FACILITY STAFF TACTICS TO PERSUADE DETAINEES TO CANCEL HEARINGS

The majority of applications to the Mental Health Review Board for a review panel are cancelled before the scheduled hearing takes place. For example, as can be seen in the figures below, in 2016 the Mental Health Review Board received 2152 applications for review panels and only 740 proceeded to hearing.<sup>5</sup> As discussed in [Section 1 | Detention Decisions](#), there were at least 20,008 involuntary admissions in BC in the 2015-16 fiscal year, which means only a small fraction of detentions are subject to review by an independent tribunal. It is difficult to assess the reasons that detainees cancel their review panel hearings. A treating physician can decide to discharge a detainee at any point in time, rendering a review of detention moot. However, the unfortunate reality of a system that places the onus on individual detainees to request a review panel is that it leaves detainees open to pressure from other people not to make a request or to cancel requests for review panels.

### MENTAL HEALTH REVIEW BOARD APPLICATION AND HEARING STATISTICS



The concern that detainees cancel their review panels in response to pressure from others prompted the Mental Health Law Program and Access Pro-Bono to generate an optional form for detainees to use when contacting the Mental Health Review Board to cancel their hearing. The purpose of the form is to inform detainees of their right to a hearing and the consequences of cancelling a hearing. The optional form was distributed to various mental health facilities in the hope that facility staff would provide the form to detainees who are contemplating cancelling their hearing. However, the Mental Health Review Board reports that the optional form is used only infrequently to cancel hearings.<sup>6</sup> The Mental Health

<sup>5</sup> Data provided by the Mental Health Review Board Acting Chair [16 June 2017].

<sup>6</sup> Interview of Mental Health Review Board Acting Chair [15 February 2017].

**CANCELLATION OF REVIEW PANEL HEARING FORM: The optional cancellation of review panel hearing form that the Mental Health Law Program and Access Pro-Bono generated to address the concern that detainees were being pressured into cancelling their review panels without adequate information on their legal rights.**

**CANCELLATION OF MY REVIEW PANEL HEARING**

I, \_\_\_\_\_ do not wish my review panel hearing set for  
(patient's name)

\_\_\_\_\_ to proceed. Instead, I wish to (check one option):  
(date of hearing)

☐

**Postpone** or delay my review panel hearing which is more than 48 hours away (only counting business days) and I understand that it may take more than two weeks to reschedule the hearing, **OR**

☐

**Withdraw** my application for a review panel hearing and I know that I cannot reapply for another hearing until after my next involuntary detention/certification by my doctor which could be \_\_\_\_\_ (ask doctor, nurse, case manager for this date.)

because: \_\_\_\_\_

I understand that:

- **If I decide to withdraw my application for a review panel hearing, then** I am giving up my right to request a review panel hearing during my current period of involuntary detention/certification; and
- My doctor is the only one who can cancel my current certification; and
- I can talk to a lawyer before signing this form. If I do not have a private lawyer, I can contact the Community Legal Assistance Society's Mental Health Law Program (MHLP) at 604-685-3425 (or 1-888-685-6222), or Access Pro Bono's Mental Health Program at 604-482-3195 ext. 1513 (or 1-877-762-6664. ext. 1513) to ask questions before signing this form.
- Fax completed form to Mental Health Review Board: 604-660-2403

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Witness' name

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Printed witness name



Review Board office practice is that a hearing may be cancelled with a written note in any format or by the detainee speaking directly to the Registrar or the Chair.<sup>7</sup> The Mental Health Review Board office will no longer cancel a hearing when they receive phone calls from facility staff or mental health team members attempting to cancel a hearing on behalf of a detainee because of concerns that health care providers are interfering with detainees' access to review panels.<sup>8</sup>

Several other Canadian jurisdictions have taken the approach of ensuring that there is a minimum level of periodic automatic review of the appropriateness of detention regardless of whether detainees take the initiative of requesting review. For example, Alberta's *Mental Health Act* states that if a patient has been involuntarily admitted for six months and has not applied for review or has withdrawn an application for review, the patient is deemed to have applied to the review panel and a hearing will be held.<sup>9</sup> Saskatchewan's *Mental Health Services Act* goes even further by requiring that a physician who issues an involuntary admission certificate authorizing the continued detention of a person after the expiration of the initial 21 day period, and any subsequent renewal to notify the review panel and that notice is deemed to be an appeal by the person being detained.<sup>10</sup>

Under Ontario's *Mental Health Act* an involuntary patient who has not made an application is deemed to have applied to the Board after the completion of the first certificate of continuation and upon completion of every fourth certificate of continuation.<sup>11</sup> Prince Edward Island's *Mental Health Act* states that involuntary patients are deemed to have applied to the mental health review board on the filing of a third certificate of renewal and at least once annually after that.<sup>12</sup> The *Involuntary Psychiatric Treatment Act* of Nova Scotia requires the mental health review board to review the file of every person detained under a declaration of involuntary admission and states that a person is deemed to have made an application to the Review Board:

- (a) sixty days from the date of the initial declaration of involuntary admission;
- (b) at the end of the sixth, twelfth, eighteenth and twenty-four month stage from the date of the initial declaration of involuntary admission; and
- (c) where a declaration of involuntary admission is still necessary after twenty-four months, every twelve months thereafter.<sup>13</sup>

## REPRESENTATIVES REPORTED

Advocates and lawyers reported that they often do not know why a detainee has cancelled a review panel hearing. For example, a lawyer who accepts a legal aid contract to represent a client and is then notified that the client has cancelled their hearing may not have even made contact with the client yet. Where there is some information available, it is often incomplete. For instance, representatives with the Mental Health Law Program will often be notified that a hearing has been cancelled, but when they try to follow up with the client, facility staff state that the client is no longer in the facility, but will not understand or

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7 *Ibid.*

8 *Ibid.*

9 R.S.A. 2000, c. M-13, s. 39(1).

10 Mental Health Services Act, SS 1984-85-86, c M-13.1, s. 34(5).

11 R.S.O. 1990, c. M.7, s. 39(4).

12 *Mental Health Act*, R.S.P.E.I. 1988, c. M-6.1, s. 16(4).

13 S.N.S. 2005, c. 42, s. 37.

know whether the individual was discharged or whether she was placed on extended leave with involuntary status under the *Mental Health Act*. If an advocate or lawyer does manage to learn that a client was put on extended leave and then cancelled his review panel, it is difficult to know whether the client cancelled his review panel because he wanted to, because he was incorrectly informed that he could not have a review panel while on extended leave, or his treating psychiatrist put him on extended leave in exchange for the detainee promising to cancel his review panel.

Even when there is an apparently straightforward reason for hearing cancellation, there could be other underlying factors. For instance, representatives reported that it is quite common for a hearing to be cancelled because a treating physician chooses to discharge a detainee immediately before a scheduled hearing. While this could simply be a function of the fact that the treating physician was of the view the detainee no longer met criteria for detention, it could also be indicative of problematic application of the detention criteria. Several representatives said that they often had the impression that when a treating physician has to actively engage with reviewing the medical chart and preparing to present the case for ongoing detention, they realize that the detainee had already ceased to meet the criteria for detention some time ago and that the detainee would be discharged at the hearing. As one representative expressed, “sometimes I wonder whether having a hearing and a lawyer hurries along the process of decertification.” Representatives reported being told by treating physicians that although they are of the opinion that the detainee still meets the criteria for detention, they discharged the detainee so they would not have to go through the work and time involved in preparing for and attending a review panel hearing.

From the information advocates and lawyers have gathered, it is clear that health care providers have a significant influence on detainees learning about and being able to exercise their legal rights. Representatives reported experiences with a wide range of health care provider attitudes towards detainees exercising legal rights, such as the right to a review panel. Several representatives reported encountering treating physicians who took a very positive approach to review panels. These physicians used the review panel as an opportunity to build their therapeutic relationship with their patients by encouraging their patients to express their views and explaining the reasons behind the decisions they are making for their patient. For example, one representative reported that she had seen psychiatrists encourage their patients to apply for a review panel, taking an approach of: “well, this is what I think, that’s what you think, here, let’s come into my office, let’s fill out the application form, we’ll go to the review panel and they’ll decide.” Many representatives expressed that this kind of engaged and positive attitude from health care providers can form an important part of a review panel’s therapeutic experience for detainees.

*I see the review panels as almost equal parts legal and therapeutic, in that, if you have a civil case or criminal case if the client’s going to lose we tell them you’re going to lose and your best bet is just to get out of this proceeding with as much money if they take a settlement or the best plea deal you can get. There’s kind of an out there. Here, for a lot of patients, particularly if they’re still in the throes of psychosis or if they’re still experiencing symptoms, they find this — and I get this almost without exception — they find it really gratifying and helpful to know that someone besides them sees what they see and puts the doctor to task... I’m not aggressive when I’m cross-examining the doctor, but I listen to the client and say ‘what problems have you had here’ and I go through that with the doctor... and that process of calmly... and logically going through the patient’s concerns with the doctor, with a panel of independent arbitrators watching everybody, on the record — almost every single client that I can think of leaves the hearing, takes a big breath before they know what the decision is and just, they tell me ‘I feel so much better now that’s been aired.’ That process of back and forth and having people hear it and getting the chance to have someone on your side ask questions is therapeutic.*

## IN THE WORDS OF THE LEGAL REPRESENTATIVES:

“I listen to the client and say ‘what problems have you had here’ and I go through that with the doctor... and that process of calmly... and logically going through the patient’s concerns with the doctor, with a panel of independent arbitrators watching everybody, on the record — almost every single client that I can think of leaves the hearing, takes a big breath before they know what the decision is and just, they tell me ‘I feel so much better now that’s been aired.’ That process of back and forth and having people hear it and getting the chance to have someone on your side ask questions is therapeutic.”

However, not all health care providers view access to legal review as a therapeutic opportunity for detainees or as a necessary component to a fair detention system. Many representatives reported that they had encountered treating physicians who saw review panels as a personal attack that challenged their clinical judgment or a waste of their time. As a result, it is evident that some health care providers exert significant pressure on detainees in an effort to deter them from exercising their right to a review panel. Representatives reported numerous examples of tactics that detaining facility staff have used that they saw documented in medical charts, were communicated to them directly by facility staff, or were conveyed to them by their clients. These tactics can be roughly divided into four categories: inducements, threats, pressure, and active interference.

First, representatives reported several examples of detaining facility staff offering detainees inducements not to request a review panel or to cancel a scheduled review panel, including:

- Offering to give detainees privileges, such as clothing access, day passes to the community, internet access, or smoke breaks in exchange for cancelling their hearing;
- Offering to put detainees out on extended leave in exchange for cancelling their hearing; and
- Offering to discharge detainees earlier than intended or at some promised date in the near future in exchange for cancelling their hearing, sometimes following through on the promise of discharge after the detainee cancels the review panel and sometimes not.

Second, representatives reported several examples of detaining facility staff threatening detainees with negative consequences for requesting a review panel or not cancelling a scheduled review panel, including:

- Threatening to revoke privileges, such as day passes to the community, unless detainees cancel their hearing;
- Misinforming detainees that if they apply for a review panel it prolongs detention because of the time involved in waiting for the hearing;
- Misinforming detainees that if they go through with a review panel hearing and the panel orders that detention continue, the health care provider will have to detain the individual longer than originally intended if they had not gone to the review panel; and

- Telling detainees that the review panel is pointless because the health care providers will immediately recertify the detainee after the review panel even if the panel orders discharge.

One representative reported a particularly poignant example of a threat that caused her client to cancel her upcoming review panel hearing. The client had a child who had been apprehended by the Ministry of Children and Family Development and she said that her treating physician told her that the Ministry of Children and Family Development might look down on the fact that she was requesting a review panel because it made her look difficult and non-cooperative, which would hurt her chances to regain custody of her child. The client withdrew her request for a review panel hearing as a result, but expressed to her lawyer afterwards that she regretted cancelling the hearing.

Third, there were several examples representatives reported of detaining facility staff exerting pressure on detainees to convince them not to request or to cancel a review panel, including:

- Telling detainees to cancel their review panel because they were going to lose;
- Telling detainees that a review panel is not in their best interests because they were unwell or it would be a stressful experience;
- Telling detainees that they should be focusing on trying to get better, not trying to get free;
- Telling detainees that they were wasting the tax payer money involved in scheduling a hearing or telling detainees that hearings cost thousands of dollars; and
- Telling detainees that they were wasting everyone's time by going to hearing.

Finally, representatives reported some egregious examples of active interference with a detainee's right to a review panel by detaining facility staff. For instance, some representatives reported observing a health care provider cancelling an involuntary certificate when the detainee agreed to stay on the ward as a voluntary patient, waiting until the review panel hearing was cancelled, and then immediately detaining the individual again with fresh certificates. One representative reported an example in which her client was decertified, but facility staff would not physically let him off the locked ward until the hearing was cancelled and then the treating physician immediately re-certified the individual. The Mental Health Review Board Chair intervened in that circumstance to reschedule another hearing for the individual as soon as possible.

Many representatives also reported observing notes in the medical chart made when a detainee asked questions or made comments about pursuing their legal rights, which the detaining facility staff had interpreted as a symptom of mental illness. The most common example reported was a health care provider who saw a detainee's desire to go to a review panel hearing as an indication that the detainee lacked insight into their mental illness and the need to be detained. Another way this was often framed in medical records was that the detainee was focused on their upcoming panel or regaining their freedom, which was an inappropriate distraction from treatment. Some representatives

When detainees asked questions or made comments about pursuing their legal rights, the detaining facility staff interpreted it as a symptom of mental illness.

## SUMMARY OF RECOMMENDATIONS

### PERSUADING DETAINEES TO CANCEL HEARINGS

For the BC Government:

- Review and amend the *Mental Health Act* to ensure legal reviews of detention take place at certain periodic intervals for all detainees.

For the Ministries of Health and Mental Health and Addictions in conjunction with the health authorities:

- Create standardized provincial policies and training to correct the current practice of some detaining facility staff in offering inducements, making threats, exerting pressure, and actively interfering with detainees exercising their legal right to seek review of their detention.

reported seeing detaining facility staff describe detainees who asked questions or made comments about legal rights as “litigious”, “grandiose”, “manic”, “uncooperative”, or “fixated”. One of the representatives described that as a detainee, “your behaviour, your actions, your decisions—especially when you’re on an inpatient unit—they’re all viewed through the prism of mental illness.” She went on to explain that a joke could be seen as delusional and a concern that a neighbour was spying on you could be seen as paranoid, even if it was true. As a result, an application for a review panel could be interpreted by some detaining facility staff as a sign that you lack insight into your mental health problems.

## CONCLUSION AND RECOMMENDATIONS

A legislative amendment to provide for a minimum level of periodic review is long overdue in BC and will go some way to reducing the burden on detainees to apply for review panels and catch individuals who have fallen through the cracks in prolonged or legally inappropriate detentions. Although there are many reasons that so few detainees exercise their right to seek review of their detention, it is clear that some detaining facility staff are contributing to this problem by offering inducements, making threats, exerting pressure, and actively interfering with detainees seeking review of their detention. The efforts to interfere with detainees’ rights to review is particularly alarming in BC, where detainees must rely on detaining facility staff for legal rights information on detention and renewal, as discussed in section 3 | [Access to Information and Legal Advice](#). This interference with a detainee’s access to justice must be stopped immediately by those in positions of leadership in the relevant Ministries and health authorities. Review of detention is not only a constitutional requirement of any administrative system for detention, it can also be an important and therapeutic experience for detainees to present their perspective at review panels.

The **BC Government** should review and amend the *Mental Health Act* to ensure legal reviews of detention take place at certain periodic intervals for all detainees, regardless of whether they are in designated facilities or on extended leave through ss. 37 or 38 of the *Mental Health Act*.

Regardless of legislative reform, the **Ministries of Health and Mental Health and Addictions should work in conjunction with the health authorities** to create standardized provincial policies and training to correct the current practice of some detaining facility staff in offering inducements, making threats, exerting pressure, and actively interfering with detainees exercising their legal right to seek review

of their detention. Health care providers involved in *Mental Health Act* detention should have sufficient training to understand the function of review panels and provide a clear explanation to detainees of their rights and eligibility to apply for a review panel.

## SCHEDULING, POSTPONEMENTS, AND CANCELLATION OF HEARINGS

The Mental Health Review Board is required to schedule review panel hearings in accordance with the provisions of the *Mental Health Act* and *Mental Health Regulation* discussed in the overview of this section. The Mental Health Review Board has also created its own Rules of Practice and Procedures which contain rules affecting the scheduling, postponement, and cancellation of review panel hearings. Rule 13.1 states that a hearing may be adjourned once it has commenced at the discretion of the review panel. Rule 13.3 permits a patient to request a postponement of a hearing more than 48 hours before the scheduled commencement of the hearing without reason. Rule 13.4 states that the Board will only grant a postponement of a hearing within 48 hours of the scheduled hearing time if a patient gives a satisfactory reason or one is apparent to the Board. When a detainee requests an adjournment or postponement to a hearing the Board takes the position that they have waived their entitlement to have their hearing scheduled within any particular timeline.

The Mental Health Review Board has also created the following rules regarding cancellation/ withdrawal of a hearing:

*“Withdraw” means to unilaterally discontinue a proceeding and it has the same operative effect as a settlement. (A withdrawal from a hearing precludes a hearing until after the next certification renewal.)*

*7.1 At any time before a hearing begins (but not after the start of a hearing), a patient may withdraw his/her request for a hearing (section 25(2.7) of the Act). This withdrawal must be sent to the Board office in writing signed by the patient/advocate or be requested in person. Upon withdrawal, the patient can only reapply for a hearing after the next certification renewal.*

The 48 hour deadline for requesting postponements and the rule that cancelling a hearing precludes a hearing until the next certification renewal were introduced by the Mental Health Review Board as cost saving measures.<sup>14</sup> The Board has to pay the review panel members a partial fee if a hearing is cancelled or postponed within 48 hours of the scheduled hearing, but does not have to pay members anything if a hearing is postponed or cancelled more than 48 hours in advance.

The *Mental Health Regulation* sets out the procedure to be followed for scheduling a hearing for patients who have been detained under the *Mental Health Act* on extended leave or in an approved home under ss. 37 or 38 for 12 or more consecutive months without requesting a hearing:

The Mental Health Review Board has created a rule that a detainee who cancels a hearing is not allowed a hearing during the certification period.

<sup>14</sup> Interview of Mental Health Review Board Acting Chair [15 February 2017].



- 7 (1) The director must give written notice to the review panel office of any patient to whom section 25 (1.1) of the Act applies.
- (2) At the request of a chair, the director must deliver to the chair a copy of the treatment record of a patient referred to in subsection (1).
- (3) For the purposes of a review under section 25 (1.1) of the Act, a chair may discuss the patient's treatment and care needs with
- (a) the patient's treating physician, or
  - (b) any other health professional who is providing, or has provided, treatment or care to the patient.
- (4) If a hearing is ordered under section 25 (1.1) of the Act respecting a patient, the patient may cancel the hearing at any time before the hearing begins.

## REPRESENTATIVES REPORTED

### Postponements and Cancellations

There are many reasons why detainees and their legal representatives request postponements to scheduled review panel hearings. As discussed in the [Introduction](#) section, detainees frequently requested a hearing postponement in recent years because they had been denied an advocate or lawyer to represent them at their hearing and they hoped that one might be available at a later date. Representatives also reported that a frequent scenario for requesting a postponement is when a treating physician places a detainee on extended leave immediately before a hearing. In the ensuing confusion, it is often unclear whether the detainee has been discharged or put on extended leave, whether the detainee still wants to proceed with hearing, whether the treating physician has changed from a psychiatrist in a facility to a psychiatrist with a community based mental health team, and whether the hearing location has now changed. Some representatives observed that there have been growing challenges in getting in contact with clients with the increasing use of extended leave. With rising poverty levels and inadequate housing, many clients on extended leave do not have phones or stable housing and sometimes legal representatives have to request a postponement to a hearing simply because they have not been able to make contact with their client.

Representatives reported that for the most part the Mental Health Review Board was responsive in granting postponements when justified in the circumstances. However, some representatives were of the view that the Board sometimes unreasonably denied postponements or only granted them grudgingly. Some representatives reported that the Board office staff conveyed displeasure with postponement requests, even those that were received just in advance of the 48 hour deadline because it did not give staff much time to cancel the hearing. In most adjudicative settings, courts and tribunals consider postponement requests by balancing the potential for prejudice to the opposing party. For instance, in a BC Human Rights Tribunal hearing where an employer requests a postponement, the tribunal would consider the effect a postponement would have on the employee who has an interest in resolving the dispute and gaining access to accommodation. However, at review panel hearings, while the detaining facility may experience scheduling inconvenience in sending a case presenter to a postponed hearing, the facility does not have any of its own interests at stake in the hearing that may be prejudiced by postponement.

Several representatives were of the view that the Board's rule that detainees are not permitted to reapply for a hearing after they have cancelled one was not only unfair to detainees, but also a violation of the *Mental Health Act* right to a review panel every certification period. Representatives pointed out that detainees cancelled hearings for many reasons, including because they were struggling with their mental health symptoms or because they were pressured into cancelling their hearing by detaining facility staff.

As one representative pointed out, the 48 hour postponement deadline was created solely based on the financial considerations for the Board, not the needs of the detainees whose interests are at stake.

However, the primary concern expressed by representatives about postponements was the lack of clear timelines or process for rescheduling postponed hearings. Once a detainee has been granted a postponement, the Mental Health Review Board takes the position that it is no longer bound by the prescribed timelines for rescheduling the hearing. With a constant influx of new requests for review panel hearings, the Board prioritizes scheduling the new hearings that must be scheduled within the prescribed timelines. As a result, representatives reported that some postponed hearings take months to reschedule and others never get rescheduled at all. One representative reported that her client had to wait for nearly 4 months for a postponed hearing to be rescheduled. The Board does not have any policies or rules that address the process for rescheduling postponed hearings.

Several representatives were of the view that the introduction of the Board's rule that detainees are not permitted to reapply for a hearing after they have cancelled one was not only unfair to detainees, but also a violation of the *Mental Health Act* right to a review panel every certification period. Representatives pointed out that detainees cancelled hearings for many reasons, including because they were struggling with their mental health symptoms or because they were pressured into cancelling their hearing by detaining facility staff. Representatives reported that the Board occasionally permitted clients to have a hearing within the same certification period after cancellation as an exception if the legal representative advocated that there were compelling circumstances that demonstrate the detainee was coerced into cancelling the hearing. However, representatives pointed out that many detainees may not have sufficient knowledge or tenacity to gather the evidence and present the argument that they were coerced into cancelling their panels after learning of the Board's rule.

### Section 25(1.1) Hearing Ordered by Mental Health Review Board Chair

In practice, s. 25(1.1) hearings are rarely ordered by the Mental Health Review Board Chair for detainees who have been on extended leave or in an approved home for more than 12 consecutive months without a hearing. Of the 21 representatives interviewed, three reported having represented a client once and one reported representing clients twice, for a total of five s. 25(1.1) hearings out of the entire sample. All four representatives commented that the s. 25(1.1) hearings took place many years ago and that they had

not seen a s. 25(1.1) hearing ordered in recent years. The experiences of these representatives with the s. 25(1.1) hearings reflect precisely the concerns that automatic hearings are put in place to address. One representative reported that his client had had no idea that he was entitled to a review panel for a very long time. Another reported that both the clients she represented at s. 25(1.1) hearings were fairly passive individuals who had not created any trouble for the facility they were in and it seemed their detention went unnoticed. Both were discharged at the review panel.

Many representatives expressed concern that there are patients who have been under long-term detention for years without a s. 25(1.1) hearing being ordered by the Chair. One representative pointed out that there were many steps that have to be taken for a hearing to take place under the provision. First, the director of the facility must have some sort of system for tracking how long the residents in a facility have been detained and how long it had been since their last review panel. Once the director of a facility has become aware that a resident had been detained for more than 12 consecutive months without requesting or having a review panel the director must notify the Chair of the Mental Health Review Board. The Chair may obtain the detainee's treatment record and discuss his treatment with health care providers in assessing the likelihood of discharge.<sup>15</sup> The Ministry of Health, health authorities, and Board have not published any policies, guidelines, or rules that address how they are monitoring any of these steps or how they make any of these decisions. Representatives expressed concern about how s. 25(1.1) was functioning as a safeguard against long-term detention with no mandatory oversight or review.

When notice is sent by the director that a resident has been detained for more than 12 consecutive months without requesting or having a review panel, the Mental Health Review Board Chair typically relies on a review of medical records, but does not speak with the treating physician in assessing the likelihood of discharge.<sup>16</sup> When the Chair concludes that a detainee's discharge is not likely, the Board sends a letter informing the detainee of that assessment.<sup>17</sup> If the Chair concludes discharge is likely and orders a hearing, the *Mental Health Regulation* states that a detainee may cancel the hearing at any time before the hearing begins.<sup>18</sup> However, the current practice of the Board is to send a letter informing the detainee of the conclusion that discharge is likely and inquiring whether the detainee would like a hearing.<sup>19</sup> The Chair only orders a hearing if the detainee takes the step of responding that he would like to proceed to a hearing.<sup>20</sup>

In 2008 the Board initiated a project in which it wrote to the directors of several facilities in the province to request a list of individuals who had been detained for 12 or more consecutive months without requesting or having a review panel.<sup>21</sup> The Board discovered that there were many facilities that had not been observing the legal requirement to notify the Chair of residents in those facilities in such situations.<sup>22</sup> The Board reviewed the files of individuals who had been in detention for as long as 13 or 14 years without review.<sup>23</sup> The initiative resulted in a flood of requests for review panels from this population of individuals in prolonged detention.<sup>24</sup> While the Board still has concerns that there are facility directors who are not

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15 *Mental Health Regulation*, s. 7.

16 Interview of Mental Health Review Board Acting Chair [16 June 2017].

17 *Ibid.*

18 *Mental Health Regulation*, s. 7(4).

19 Interview of Mental Health Review Board Acting Chair [16 June 2017].

20 *Ibid.*

21 *Ibid.*

22 *Ibid.*

23 *Ibid.*

24 *Ibid.*

complying with the notification requirements, the Board does not have sufficient resources to conduct the initiative again to remind facilities of their legal obligations.<sup>25</sup>

## CONCLUSION AND RECOMMENDATIONS

As previously discussed, a legislative amendment to provide for a minimum level of periodic review of detention will go some way to improving oversight and safeguards for individuals in prolonged or legally inappropriate detentions. The safeguard provided by s. 25(1.1) for detainees on leave or transferred to an approved home under ss. 37 or 38 for 12 or more consecutive months without requesting or having a review panel is inadequate to provide effective oversight of prolonged detention for a number of reasons. It provides no protection to detainees who remain in prolonged inpatient detention who are not placed on leave. It relies on facility directors monitoring the detention periods and review panels of facility residents to notify the Chair of the Mental Health Review Board—a legal requirement that directors do not appear to be consistently fulfilling. Even once notified, the Chair's process of conducting a pre-screening to assess the likelihood of discharge is a concerning one. Detainees who receive a letter indicating that in the opinion of the Chair there is no reasonable likelihood of discharge following a review panel may be confused or deterred from exercising their right to request a review panel. The practice of sending a letter indicating that in the opinion of the Chair there is a reasonable likelihood of discharge following a review panel hearing still places an onus on detainees to take action to obtain a hearing despite the fact that there is a reasonable likelihood that the detention is not legally appropriate.

The **BC Government** should review and amend the *Mental Health Act* to ensure legal reviews of detention take place at certain periodic intervals for all detainees, regardless of whether they are in designated facilities or on extended leave through ss. 37 or 38 of the *Mental Health Act*.

Regardless of legislative reform, the Mental Health Review Board can take steps to improve access to independent review of detention. Section 25 of the *Mental Health Act* states that a detainee is “entitled ... to a hearing by a review panel” within each certification period. While the Board has the power to control its own process and make rules and orders respecting practice and procedure at review panel hearings, it does not have authority to abrogate a right guaranteed by statute.<sup>26</sup> In the current mental health administrative system, only a small minority of detentions are subject to review by a review panel. Many detainees are pressured into cancelling their review panel hearings by the health care providers responsible for their detention. The Board has precluded detainees who have cancelled a hearing from requesting a hearing until the next certification period based solely on the costs consideration for the tribunal. In a free and democratic society, the government's interests in reducing a tribunal's funding cannot outweigh the significant constitutional rights at

A minimum level of periodic review of detention will go some way to improving oversight and safeguards for individuals in prolonged or legally inappropriate detentions.

<sup>25</sup> *Ibid.*

<sup>26</sup> *Administrative Tribunals Act*, S.B.C. 2004, c. 45, ss. 11, 14.

## SUMMARY OF RECOMMENDATIONS

### SCHEDULING HEARINGS

#### For the BC Government:

- **Review and amend the *Mental Health Act* to ensure legal reviews of detention take place at certain periodic intervals for all detainees.**

#### For the Mental Health Review Board:

- **Eliminate rule 7.1 that precludes detainees who have cancelled a hearing from requesting a hearing until the next certification period.**
- **Address the process and timelines for rescheduling postponed hearings.**
- **Address the process for implementing *Mental Health Act*, s. 25(1.1).**

#### For the Ministries of Health and Mental Health and Addictions in conjunction with the health authorities:

- **Create standardized provincial policies and training for facility directors in monitoring detention lengths to fulfill *Mental Health Act*, s. 25(1.1).**

stake for detainees who are deprived of their liberty and face significant consequences from being detained under the *Mental Health Act*.

The Mental Health Review Board faces challenges in coordinating the schedules of three panel members, the detaining facility's case presenter, the detainee, and the detainee's representative to schedule hearings. However, the Board has not taken sufficient steps to create an organized process and timelines for rescheduling postponed hearings and to make that information available to detainees and their representatives. Similarly, the Board has not made public what the Chair's process is for ordering s. 25(1.1) hearings. Given that review panel outcomes vary greatly and no review panel decisions are published, it is not clear what factors the Chair considers in assessing the likelihood that a review panel would order discharge. Transparency of the factors considered in reaching decisions is a fundamental procedural fairness requirement of any administrative system. In the absence of any level of automatic review of detention in the BC *Mental Health Act*, the Chair should be interpreting s. 25(1.1) as broadly as possible to improve access to justice for individuals in prolonged detention.

The **Mental Health Review Board** should eliminate rule 7.1 from the Rules of Practice and Procedures that precludes detainees who have cancelled a hearing from requesting a hearing until the next certification period. The **Mental Health Review Board** should also amend its Rules of Practice and Procedures or produce policies or guidelines to address the following issues:

- The process and timelines detainees can expect for rescheduling postponed hearings; and
- The process followed in monitoring patients who have been detained under the *Mental Health Act* on extended leave or in an approved home under ss. 37 or 38 for 12 or more consecutive months without requesting a hearing and the factors considered in assessing the likelihood of discharge to order a s. 25(1.1) hearing.

Regardless of legislative reform, the **Ministries of Health and Mental Health and Addictions should work in conjunction with the health authorities** to create standardized provincial policies and training to address the process followed by facility directors in monitoring patients who have been detained under the *Mental Health Act* on extended leave or in an approved home under ss. 37 or 38 for 12 or more consecutive months without requesting or having a review panel.

## BARRIERS TO ADEQUATE AND TIMELY DISCLOSURE OF MEDICAL RECORDS TO PREPARE FOR A HEARING

It is a fundamental component of any legal process involving detention that the state must disclose the evidence in support of detention in advance of a hearing. In the Canadian legal system, parties do not arrive at hearings unprepared and “litigate by surprise”. To ensure a legal proceeding is fair, you are entitled to know the case that you have to meet at the hearing and have an opportunity to prepare your response. A party’s failure to disclose relevant evidence in advance of a hearing deprives the responding party of the opportunity to know the case to meet and prepare their response and may render the entire tribunal hearing procedurally unfair.<sup>27</sup> In the administrative system for *Mental Health Act* detentions, this means that detaining facilities and mental health teams have a legal obligation to disclose any records in their possession that could be relevant to detention. These records include the mandatory legal forms that are completed pursuant to the *Mental Health Act* and *Mental Health Regulation*, nurses’ notes, and reports prepared by treating physicians, among other things.

Unfortunately, as will become clear from the representative responses below, staff at detaining facilities and mental health teams have an extremely poor understanding of their obligations to disclose relevant records in legal proceedings like review panels. Questions on the topic of adequate and timely disclosure of records elicited the strongest responses from legal representatives. Representatives were unanimous in reporting that they had encountered barriers in disclosure from detaining facilities and mental health teams, ranging from a complete refusal to disclose records in advance of a hearing, to elaborate demands being imposed on legal representatives in order to gain access to records, to documents being disclosed with inappropriate redactions.

Failure to comply with disclosure obligations is largely due to inadequate training of facility staff and mental health team members. There is a well established body of common law authority that governs disclosure rights and obligations of parties to a legal proceeding that staff would not likely be aware of unless the Ministry of Health, health authorities, or the facility directors provided adequate policies or training on the topic. For instance, many facility staff members are under the false impression that detained individuals and their legal representatives preparing for a review panel hearing must request their medical records through the process set out in the *BC Freedom of Information and Protection of Privacy Act*.<sup>28</sup> This would be akin to requiring an accused facing criminal charges or a complainant in a human rights tribunal proceeding to submit freedom of information requests to obtain disclosure. In fact, the common law right to disclosure for parties to a legal proceeding exists independently of any freedom of information statute. The *BC Freedom of Information and Protection of Privacy Act* explicitly excludes disclosure in a legal proceeding from the scope of the Act in s. 3(2), which states that the Act does not limit the information available by law to a party to a proceeding.

However, the long standing issue of inadequate disclosure from detaining facilities has been made worse by the silence of the *Mental Health Act*, the *Mental Health Regulation*, and the Mental Health Review Board Rules of Practice and Procedures on the topic of disclosure. While the right to disclosure exists for any detainee who requests a review panel independently of the statute, regulation, and the Rules of Practice and Procedures, clarification of disclosure rights and obligations would go a long way to improving procedural fairness at review panels. Some Canadian jurisdictions have opted to set out the rights of detainees

<sup>27</sup> See for instance, *Napoli v. Workers’ Compensation Board* (1981), 126 D.L.R. (3d) 179.

<sup>28</sup> R.S.B.C. 1996, c. 165.



and their legal representatives to access medical records in mental health statutes. For example, in New Brunswick, patient advocates have an express statutory right to free access to the books, records and documents relating to people who are subject to examination or who are involuntarily admitted under the *Mental Health Act*.<sup>29</sup>

For the most part in BC, disclosure rights and obligations are set out in a tribunal's rules of practice and procedure. For example, the BC Criminal Code Review Board, which reviews the liberty restrictions of an individual found not criminally responsible by reason of mental disorder, has several rules regarding pre-hearing disclosure of evidence in its Procedural Guidelines at Hearings. Disposition information in the form of written documents to be considered by the Criminal Code Review Board must be submitted to the Criminal Code Review Board for distribution to all parties 14 days prior to the date of the hearing.<sup>30</sup> Even tribunals that adjudicate issues unrelated to detention impose pre-hearing disclosure rights and obligations through rules of practice and procedure. For example, the BC Residential Tenancy Branch Rules of Procedure has a set of rules governing the obligations and timelines for submitting and exchanging evidence in advance of a dispute resolution hearing.<sup>31</sup> The BC Human Rights Tribunal has an entire Part of its Rules of Practice and Procedure that set out parties' pre-hearing obligations to promptly deliver copies of any documents that may be relevant.<sup>32</sup>

## REPRESENTATIVES REPORTED

### Detaining Facility's Failure to Comply with Pre-Hearing Disclosure Obligations

The only consistent theme among representatives' responses was that there is absolutely no consistency among detaining facilities' record disclosure practices. Some facility staff provided immediate and unfettered access to a detainee's complete medical records and permitted legal representatives to copy whatever they wanted. Other facilities promptly delivered medical records via fax or email. However, some facility staff told representatives that *Mental Health Act* patients were never permitted to see their own records. There is no standardized record disclosure policy or practice among facilities in the same health authority and sometimes no standardized policy or practice among staff at the same facility. Even when representatives reported that they had learned a particular facility or ward's practice regarding record disclosure, it could change with staff turnover. Several representatives expressed that it seemed as if the health authorities have no coherent understanding or position on what law or policy governs their disclosure obligations in review panel proceedings.

Representatives focused their comments about disclosure on detaining facilities and as a result, this discussion will also focus on facilities. However, it is reasonable to infer that many of the issues that legal representatives encounter with facilities are similarly problems for mental health teams who are responsible for disclosing records for detainees on extended leave. While some representatives observed that mental health teams in community have better disclosure practices than facilities, others reported experiencing similar challenges in obtaining records from mental health teams in the community. For example, one representative explained during the interview that she had a hearing scheduled in two days to represent a detainee on extended leave and the last content in the records she had received was six months old. When

29 R.S.N.B. 1973, c. M-10, s. 7.6(6).

30 British Columbia Review Board, *Procedural Guidelines at Hearings*, r. 7.2.

31 British Columbia, Residential Tenancy Branch, *Rules of Procedure*, r. 3.

32 British Columbia Human Rights Tribunal, *Rules of Practice and Procedure*, Part 6.

she made inquiries, it seemed that the treating psychiatrist had seen her client twice in the last six months, but the notes had been sent away for dictation and since the psychiatrist was away, no one knew who would be presenting the case for detention at the hearing and whether they would have access to the notes. Like nearly all detainees, her client wanted to proceed with the hearing as scheduled despite the lack of any current information about the case for detention.

Lawyers who practiced in other areas of law frequently pointed out that the failure of detaining facilities to provide adequate and timely disclosure in the civil mental health context would be completely unheard of and unacceptable in any other legal proceeding. Representatives who practiced in areas as diverse as civil litigation, immigration and refugee law, personal injury litigation, family law, criminal defence, administrative law, and forensic mental health law reported that disclosure practices were by far the worst in review panel proceedings. Many parties to legal proceedings in other areas of law face similar challenges that detaining facilities do in review panel proceedings, such as organizing voluminous medical records, working with tight timeframes, or dealing with contemporaneous and forward-looking legal questions. Some representatives pointed out that as state representatives, detaining facilities have significantly more power and resources than *Mental Health Act* detainees and likened review panel proceedings to criminal proceedings or immigration detention proceedings in which the state has a strict obligation to make full and fair disclosure in presenting the case for detention.

Many representatives encountered flat out refusals to grant any level of access to records. One representative reported that detaining facility staff called her supervisor to complain about her attempts to get access to her client's records. Others were told that it was "illegal" to copy their client's records or that it was facility policy never to show patients or their legal representatives records. Some representatives reported having to attend a hearing and tell the review panel that the detaining facility had failed to provide any level of disclosure. Even once told by the review panel to disclose copies of the records, some case presenters expressed a great deal of resistance to the panel.

While there are examples of prompt and unrestricted disclosure or complete refusal to fulfill disclosure obligations, representatives reported that the most common experience was that facilities eventually provide some level of disclosure after legal representatives engaged in extensive efforts and administrative procedures to gain access to medical records. These facility requirements were described by representatives as "elaborate", "arbitrary", "impossible", and "very time consuming". For example, some facilities will not accept the authorization that legal representatives obtain from their clients to gain access to their records, but instead insist that legal representatives use an authorization form specific to the detaining facility or regional health authority. For advocates and lawyers who represent clients in different facilities or health authorities, this means keeping track of multiple different formats of authorization forms for different facilities.

Representatives reported elaborate procedures to obtain disclosure, for instance, some facilities insist that legal representatives obtain a written authorization from their client in person, call the records department to tell them that the authorization

The failure of detaining facilities to provide adequate and timely disclosure in the civil mental health context would be completely unheard of and unacceptable in any other legal proceeding.

will be faxed, fax the authorization from the ward, wait on the ward for the records department to call the ward to confirm that they have received the authorization, and then return to the facility in person several days later to obtain copies from the records department. Even once that process is complete, some facilities take the position that the authorization is only valid for the legal representative to see records up to the date the authorization is signed by the detainee, not the date of the hearing. This means that facilities make legal representatives go through this entire process multiple times in order to obtain records up to the date of the hearing.

Detaining facility staff often told representatives that the request for records would take a prolonged length of time to process—anything from one week to 30 business days. Given that legal representatives often only have a matter of days to prepare for a hearing, these projected timelines would mean that records were delivered after the hearing concluded. Some facility staff erroneously referenced the *BC Freedom of Information and Protection of Privacy Act* when asserting that they had 30 days to provide the records. One representative reported being told that facilities would charge detainees “rush fees” for producing records with anything less than 30 days’ notice.

Several representatives expressed that facility staff often conveyed an attitude through words or actions that record disclosure was unnecessary and a waste of their time. For instance, one representative reported that he had to “beg” for record disclosure and facility staff acted like they were providing access to records as a favour to him. Another reported that she was told by facility staff that it was not their job to give her copies of the records. Some facility staff told representatives they would not process the records disclosure request until immediately before the review panel hearing because the hearings cancel too often, leaving the legal representative with no opportunity to prepare for the hearing.

When facilities do deliver disclosure, it is sometimes incomplete, out of order, and granted with little to no time to prepare with the evidence. Several representatives reported that they sometimes only received disclosure a day before the hearing or the morning of the day the hearing is scheduled. For instance, one representative described receiving 300 pages of disorganized records two hours before the hearing. Many representatives reflected on how much time it takes to read the records—detaining facilities do not list the documents or organize them in any way, and they contain health care providers’ hand written notes, which can be very challenging to read. Several representatives said that the most useful part of the medical records in terms of understanding the case for detention was the case presenter’s report to the review panel. However, this report was almost never produced in advance of the hearing, but instead was provided by the case presenter at the beginning of the hearing itself, if produced at all.

Finally, several representatives expressed serious concern that however hard it is for legal representatives to gain access to records, it is even harder for detainees who are representing themselves at review panel hearings. On a practical level, it is challenging for someone experiencing mental health problems who is under the influence of psychotropic pharmaceutical agents and in a situation of an extreme power imbalance to exercise the kind of sustained determination necessary to obtain records and organize a case to present for discharge. But in addition to these challenges, many representatives reported being told by detaining facility staff that *Mental Health Act* detainees were not permitted to see their own medical records or were only permitted to request them on discharge. When facilities provided disclosure to legal representatives, staff sometimes asked representatives not to disclose the clients’ own medical records to them. Some representatives expressed that the longstanding lack of adequate legal aid funding that resulted in hundreds of detainees being denied legal representation at review panels for the last several years may form a part of the reason why so many detaining facilities do not understand their disclosure obligations.

## Detaining Facility Presents Evidence at Hearing that was Not Disclosed

Given the significant failings of pre-hearing disclosure, it is not surprising that all representatives reported experiences with detaining facilities presenting new evidence or documents at a review panel hearing that they had not seen or had a chance to prepare for. For example, some representatives reported hearings in which case presenters rely on evidence in an entire second chart that had not been disclosed. Representatives reported that facilities often failed to disclose notes or reports that are stored electronically in facility or health authority computer systems rather than printed in hard copy. One representative reported that the case presenter was referring to information in records from 15 years ago, but the records disclosed to her only went back a year. Another representative reported that a social worker who had worked closely with the detainee testified at a review panel that the detainee did not have a feasible discharge plan, but the social worker's notes were not part of the pre-hearing disclosure.

However, the most common document that detaining facilities fail to disclose in advance of the hearing is the case presenter's report to the review panel, which is typically written by the detainee's treating psychiatrist. Representatives reported that the vast majority of the time they arrive at a hearing and are given the case presenter's report for the first time when the hearing begins, which necessitates standing the hearing down for everyone to read it and to grant the detainee and their legal representative time to consult. One representative described the typical experience as the review panel being scheduled for 10:00am and the treating psychiatrist walking in with the report at 10:05am. Although the report often summarizes information that is contained elsewhere in the client's medical records, representatives reported it was common for there to be at least some new information in the report that could not be found anywhere else in the client's medical records. One representative who also does criminal defence work described the report as a kind of narrative of the detaining facility's reasons for detention and the plan for the patient. He went on to explain that a Crown prosecutor in a criminal case presents a similar kind of narrative, but a prosecutor would never be permitted to present it for the first time on the day of trial.

The typical response when one party raises evidence that has not been disclosed in legal proceedings is an adjournment to address the prejudice to the party who has not had time to prepare with the evidence or the complete exclusion of the evidence from the hearing. However, when asked what their response was when the detaining facility presented evidence that had not been disclosed, representatives unanimously responded that they had to find a way to deal with the information on the spot in the hearing. In the civil mental health context, an adjournment to the hearing necessarily prolongs detention and nearly all detainees are understandably anxious to complete their hearing. Coordinating the schedule of the panel members, the case presenter, the detainee, and the detainee's legal representative to resume an adjourned hearing in a reasonable time frame would also be logistically challenging. Only one representative who has been conducting review panels for over 25 years reported receiving instructions from a client once to adjourn a hearing in response to undisclosed evidence. Instead of seeking adjournment, legal representatives typically object, demand a copy of the undisclosed document, and ask for a short recess to review it with their client.

This strategy of dealing with undisclosed evidence has a number of significant disadvantages. First, representatives pointed out that it is an inefficient use of time for the review panel members and the case presenter. It takes time for legal representatives to review new evidence and documents with their clients and during that time, three review panel members and a physician — all of whom are paid with limited public funds — are waiting around doing nothing. Representatives reported that review panel members usually understand the need for detainees to review the information with their legal representatives and grant

## IN THE WORDS OF THE LEGAL REPRESENTATIVES:

**“I’d say 99% cent of the time [the case presenter report is presented] at the hearing ... the advocate has to go over it with the client, so, the advocate will read it to the client, one, so they get a head’s up of what the panel is reading at the very same moment and also to get the client’s response. That can be a challenging situation.”**

recesses ranging from 10 to 30 minutes depending on the volume of newly disclosed information — a fairly significant delay in a hearing that typically only takes two hours. However, some representatives reported experiences with review panel members who would not grant detainees and their legal representatives sufficient time. For example, one representative reported asking the panel for a 10 minute recess and being told she could only have 2 minutes. Other representatives reported that members had insisted that they discuss the information in newly disclosed documents with their clients in the room in front of the panel. Some representatives reported being put under time pressures to review new documents by review panel members who said that their parking would expire or they had to catch a flight.

Second, representatives reported how challenging it can be for a detainee to process the new content contained in undisclosed documents. Medical records and case presenters’ reports are written by health care providers about detainees. Given their work loads and the number of patients they provide care to, it is inevitable that health care providers sometimes record inaccurate information about detainees. For example, one representative recounted a passage in a client’s medical records about the difficulties the client was having after the death of a parent who was in fact still alive. Detainees need to identify and correct any inaccurate information before it is relied on by the review panel. In addition, detainees are also forced into the position of having their initial emotional reaction to the descriptions of them in the midst of their review panel, rather than having an opportunity to react and process this in advance of the hearing. Many representatives pointed out that when a detainee disagrees with or is hurt by the way they are described they can get upset during their hearing. This can make it even harder for detainees to engage with their legal representative and the panel in presenting their case for discharge.

Third, representatives reported that it is difficult as a legal advocate or lawyer to immediately absorb and respond to new evidence and documents while under time pressures and trying to help their client react and process the new information. The legal representatives then need to proceed unprepared with direct examination of their client and potentially other witnesses, cross-examination of the detaining facility’s witnesses, and legal submissions to the panel. This jeopardizes the fairness of the hearing and raises the potential that legal representatives will miss issues with the evidence, arguments that could be raised, or an effective line of cross-examination.

*“I’d say 99% cent of the time [the case presenter report is presented] at the hearing ... the advocate has to go over it with the client, so, the advocate will read it to the client, one, so they get a head’s up of what the panel is reading at the very same moment and also to get the client’s response. That can be a challenging situation. The challenges for the client in that situation is that is they’re getting hit with a lot of information all at once. And they’re hearing information which — some information they disagree with, some information is inaccurate, some of it is just kind of off-kilter so it’s kind of in between and so they’re having to deal with the factual underpinnings as well as the*

*emotional impact it has on them. So that's their challenge and it's exacerbated because although there's no actual timeline to do this, there is the pressure of the hearing is waiting to start for you ... In general, the panel members do understand the advocate has to spend adequate amount of time with the client to prepare, but it's not ideal. The clock's ticking. Typically what happens is the chair will come or the presenter will come and knock on the door and say 'well the panel's ready for you to go' ... they're not dictating, but there is this pressure... The challenge for the advocate is that they're also having to take in new information. They're having to, on the fly, figure out how does this new information affect what they've already prepared either in terms of question or summation. They're having to deal with the client's response ... because this is their client's life that's being commented on and interpreted. So, a client may want to address what's being said in the note because they're really offended by it, and it may have no practical effect on the criteria, but it has a practical effect on your client and so the advocate has to tend to that."*

### Level of Redaction in Detaining Facility's Disclosure

Some detaining facilities produce disclosure with certain portions of the medical records redacted or severed (blacked out so the information cannot be seen). Again, the most common response when asked about the level of redaction in detaining facility's record disclosure was that redaction practices were completely inconsistent. Representatives reported that some facilities and mental health teams did not redact any content in the medical records, while others redacted heavily. From the representatives' perspectives, health authorities are not following any consistent law or policy in redacting records. Although two representatives who practice in the lower mainland reported that facilities located in the Fraser Health Authority tended to be more likely to engage in inappropriate and unnecessary redactions, many other representatives reported that there was no consistent practice among facilities within the same health authority, or even among different staff at the same facility. For example, some representatives reported that they have been provided with medical records in advance of a hearing with redactions, but the exact same records were introduced by the facility at the review panel hearing without any redactions.

Some representatives reported receiving medical records in which the redactions were so extensive that it interfered with their ability to understand the record contents. In addition, there was often no justification or reason provided for the redaction. Although many representatives expressed that they could understand the reason for detaining facilities redacting the names of third parties in the exceptional circumstance where it was necessary to protect their identity, the redactions were often indiscriminate. Representatives reported that when they had received medical records with redacted content and had subsequently gained access to the un-redacted records, they could see that there was a very poor assessment as to whether redacting the information was necessary. Representatives reported the following examples of information that had been inappropriately redacted from a detainee:

- Notes recording what a detainee had said about a third party;
- Anything a third party had said, regardless of content;
- The name of the detainee's treating psychiatrist;
- The name of the physician who made the detention or renewal decision on Form 4s and Form 6s;
- The information about what psychiatric treatment the detainee had been administered;
- Information on the detainee's diet and meal planning; and
- The name of the facility the detainee was being held in.



## Mental Health Review Board Response to Inadequate Facility Disclosure

Representatives reported that the Mental Health Review Board has made efforts to ensure that detaining facilities comply with their disclosure obligations. For instance, several representatives who encountered flat out refusals from detaining facilities to produce medical records in advance of a hearing have found that the Chair intervened with the facility staff to explain their legal obligations. However, others have reported that certain facilities repeatedly breach their disclosure obligations despite the Chair's efforts. Some representatives said that making a formal application to the Mental Health Review Board for an order compelling disclosure in advance of a hearing could result in a postponement, which prolongs detention for their client. Most legal representatives instead proceed to a review panel with insufficient disclosure or absolutely no disclosure and try their best to respond to the disclosure while the review panel is taking place to ensure that their clients can proceed with their scheduled hearing.

At the review panel hearing, representatives reported that review panel members almost always told the detaining facility case presenter to provide the detainees and their legal representatives with copies of all undisclosed documents. However, some representatives were quick to point out that the fact that review panel members order disclosure at the hearing is no solution to the facility's failure to fulfill their disclosure obligations in advance of the hearing. As discussed in previous sections, it is extraordinarily challenging for both a detainee and their legal representative to process information disclosed on the spot in the hearing. This is detrimental both to the detainees' experience of the hearing, as well as the fairness of the procedure. As discussed, representatives reported that while most review panel members granted a reasonable recess to permit detainees and their representatives to review the newly acquired information together, some members refused to grant sufficient time.

## Adequacy of Preparation Time for Hearing

When asked whether they had sufficient time to prepare for a review panel, representatives reported that the time spent trying to overcome the obstacles created by detaining facilities in obtaining disclosure was the primary challenge in preparing for a hearing. For instance, one representative said that "inadequate time is a function of not knowing the case you need to meet." Several representatives reported that the amount of administrative work involved in trying to obtain disclosure from facilities took an inordinate amount of time — these efforts sometimes involved multiple letters, authorization forms, phone calls, and in person visits to facilities just to obtain basic document disclosure. These representatives were of the view that if facilities permitted lawyers and advocates access to their clients and fulfilled their disclosure obligations, even a few days before the hearing, there would be sufficient time to prepare for hearings.

Some of the lawyers who represent clients through legal aid funding provided by the Mental Health Law Program reported that the legal aid tariff is insufficient to cover the amount of time involved in a review panel. These lawyers expressed that the legal aid rate for a review panel hearing was well below established billing rates and the partial fee they receive for doing the preparation work for a cancelled hearing was not sufficient to cover the time expended. They reported that the insufficient hearing cancellation fee combined with the high frequency of cancelled hearings in this context are a large deterrent to accepting these legal aid files. Lawyers who represent detainees who are not financially eligible for legal aid reported charging a substantially reduced rate, because the financial eligibility cut off is so low that even detained individuals who do not qualify for legal aid often have low incomes. These lawyers described their motivation in accepting legal aid contracts or reducing fees to represent detainees as a commitment to pro-bono or low-bono work to promote access to justice for a deeply underserved population.

## CONCLUSION AND RECOMMENDATIONS

The failure of detaining facilities and mental health teams to comply with their legal obligations to provide detainees with timely and fulsome disclosure of relevant records jeopardizes the fairness of review panel hearings. The Mental Health Review Board is responsible for ensuring that evidence is only admitted and relied on at review panel hearings if detainees and their legal representatives have had sufficient time to review and prepare for the case to be met. However, unlike other tribunals, the Mental Health Review Board has not established adequate rules governing pre-hearing disclosure. The Mental Health Review Board should establish timelines for detaining facilities and mental health teams to conduct pre-hearing disclosure of the evidence that will be used to present the state's case for detention. The purpose of such a deadline would be to respect procedural fairness by enabling detainees and their legal representatives to prepare a response, not to prevent detaining facilities from adding evidence that occurred immediately before the hearing. The chair of the review panel could still maintain the flexibility to permit new evidence to be introduced that could not reasonably have been disclosed in advance of the hearing.

The **Mental Health Review Board** should take steps to address the procedural fairness violations raised by the widespread failure of detaining facilities and mental health teams in fulfilling pre-hearing disclosure obligations, which as a minimum, should include:

- Amendments to the Rules of Practice and Procedures in consultation with stakeholders to establish timelines for detaining facilities and mental health teams to conduct pre-hearing disclosure of the evidence that will be used to present the state's case for detention; and
- Amendments to the Rules of Practice and Procedures in consultation with stakeholders to ensure that all panel members grant detainees and their representatives a reasonable recess to review evidence or documents presented by detaining facilities that did not form part of the pre-hearing disclosure.

The **Ministries of Health and Mental Health and Addictions** should **work in conjunction with the health authorities** to create standardized provincial policies and training to correct the widespread inconsistencies and deficiencies in fulfilling pre-hearing disclosure obligations among detaining facilities and mental health teams. Policies and training must, as a minimum, educate staff on the rights of detainees and their legal representatives to timely and fulsome disclosure in advance of review panel hearings and set out a straightforward process for staff to promptly deliver all relevant records to detainees and their legal representatives.

### SUMMARY OF RECOMMENDATIONS

#### PRE-HEARING DISCLOSURE

For the Mental Health Review Board:

- Establish timelines for detaining facilities and mental health teams to conduct pre-hearing disclosure.
- Ensure that panel members grant detainees a reasonable recess to review evidence presented by detaining facilities that did not form part of the pre-hearing disclosure.

For the Ministries of Health and Mental Health and Addictions in conjunction with the health authorities:

- Create standardized provincial policies and training to correct the widespread inconsistencies and deficiencies in fulfilling pre-hearing disclosure obligations among detaining facilities and mental health teams.

# 6 | Review Panel Hearings and Decisions

## OVERVIEW

Review panels of the Mental Health Review Board are three member panels that review detention and decide whether a detainee continues to meet the criteria to remain detained under the *Mental Health Act*. Section 24.1(3) of the *Mental Health Act* sets out that each review panel must include:

- 1) A physician,
- 2) A lawyer, and
- 3) A community member, “who is not a medical practitioner or a lawyer”.<sup>1</sup>

Review panel members receive 1 to 2 days of training.

Review panels make decisions by majority—if two or all three members decide that an involuntary patient continues to meet the criteria, detention is continued and if two or all three members decide that an involuntary patient does not meet the criteria, detention is not continued. Review panel members are appointed by the responsible minister and the Mental Health Review Board Chair establishes review panels from among the pool of members. Lawyer members, who act as chair at review panels, receive 1.5 to 2 days of training from the Mental Health Review Board.<sup>2</sup> Physician members and community members receive 1 day of training.<sup>3</sup> All members receive a training manual which is not available to the public and observe one or two hearings before being assigned to make decisions on review panels.<sup>4</sup> There is very little in the way of ongoing professional development or training offered to panel members following this initial training.<sup>5</sup>

1 R.S.B.C. 1996, c. 288, s. 24.1. This report will use the term “lawyer” for simplicity’s sake, but the Act sets out that a member in good standing of the Law Society of British Columbia or a person with equivalent training may fill this role.

2 Interview of Mental Health Review Board Acting Chair [15 February 2017].

3 *Ibid.*

4 *Ibid.*

5 *Ibid.*

**From the perspective of many representatives, review panels hearings are adversarial — they resemble the features of other adversarial tribunal and court processes in which two parties present opposing evidence and legal arguments.**

A case presenter with the detaining facility attends the review panel hearing to present the state's case for continued detention of the involuntary patient. The case presenter is usually the detainee's treating psychiatrist, but could also be another psychiatrist in the detaining facility who is not the detainee's treating psychiatrist, a psychiatric nurse, a medical student, or a case manager or social worker with a mental health team. Review panel hearings begin with the case presenter setting out the evidence and arguments for continued detention based on the application of *Mental Health Act* criteria to the detainee. The case presenter is then cross examined on the evidence presented for detention by the detainee's advocate or lawyer, or by the detainee herself if she is not represented. Occasionally other witnesses, like social workers or family members of the detainee, provide testimony in support of detention and are cross examined.<sup>6</sup> Following that, the detainee's advocate or lawyer presents the case for detention to be discontinued through testimony from the detainee and sometimes other witnesses, like family members of the detainee who support discharge. The case presenter then cross examines the detainee. Review panel members typically ask questions of the case presenter, detainee, and other witnesses. The hearing concludes with legal arguments from the case presenter and the detainee's legal advocate or lawyer.<sup>7</sup>

From the perspective of many representatives, review panels hearings are adversarial — they resemble the features of other adversarial tribunal and court processes in which two parties present opposing evidence and legal arguments. The Mental Health Review Board previously viewed the review panel process as adversarial, stating in the 1991 *Guidelines for Review Panels Under the Mental Health Act* that at a review panel “the onus of proof is always on the hospital” and that if the detaining facility provided insufficient evidence for detention, the detention would be discontinued.<sup>8</sup> However, the Mental Health Review Board currently sees review panels as investigatory, not adversarial, and does not believe the onus of proof rests with the detaining facility.<sup>9</sup> Most hearings take approximately two hours, however, some representatives reported hearings that were as short as 45 minutes or as long as an entire day. For inpatient detainees, hearings generally take place in a meeting room or board room in the facility that the individual is detained in. For detainees on extended leave, hearings usually take place in a meeting room

6 According to s. 25(2.4) any person who satisfies the review panel that he or she has a material interest in or knowledge of matters relevant to the hearing may give evidence or make submissions at the hearing.

7 British Columbia, *Mental Health Review Board Rules of Practice and Procedures*, r. 14.4.

8 British Columbia, Ministry of Health, “Guidelines for Review Panels Under the Mental Health Act”, (Victoria: Ministry of Health, October 1991) at 16.

9 Interview of Mental Health Review Board Acting Chair [15 February 2017].

or board room at the responsible mental health team's office. Hearings are recorded by the Mental Health Review Board.

This section will begin with a discussion on review panel member appointments and the lack of protections against panel member bias and the apprehension of bias. The section will then consider the unusual practice of the Mental Health Review Board in providing funding to the detaining facility to participate in review panel hearings, but not providing any funding to detainees. The section will discuss procedural fairness issues at review panel hearings, such as inconsistencies in hearing procedures and the conduct of review panel members at hearings. The section will then turn to review panel decisions, including the consistency of decisions and the adequacy of written reasons for decisions. The section will conclude with a discussion of the issues with the state's case for detention being presented by the detainee's treating psychiatrist and consider potential alternatives for case presentations.

## COMPOSITION OF REVIEW PANELS

The appointment of panel members to the Mental Health Review Board is a matter of discretion for the responsible minister and the composition of specific review panels is up to the Mental Health Review Board Chair. The only constraint set out in the BC *Mental Health Act* is that members must have the qualifications set out in s. 24.1 to be appointed, and each panel must contain a physician, lawyer, and community member. The statute does not contain any provisions that address bias or the apprehension of bias among review panel members. The Mental Health Review Board Rules of Practice and Procedures are similarly silent on the topic. The guarantee of an impartial decision maker is an important component of a fair hearing, but it is equally important to any legal proceeding that there is no appearance of conflict or partiality.<sup>10</sup> This means that regardless of whether a decision maker can remain neutral, a connection between a decision maker and the parties to a proceeding that gives the appearance of unfairness is inappropriate.

Unlike BC, several other Canadian jurisdictions set out circumstances in which a conflict of interest, bias, or apprehension of bias makes a tribunal member ineligible to sit on a panel, including the Alberta *Mental Health Act*,<sup>11</sup> the Saskatchewan *Mental Health Services Act*,<sup>12</sup> the Manitoba *Mental Health Act*,<sup>13</sup> and the Newfoundland and Labrador *Mental Health Care and Treatment Act*.<sup>14</sup> As an example, s. 67 of Nova Scotia's *Involuntary Psychiatric Treatment Act* states:

### **Conflict of interest or bias**

**67(1)** A member of the Review Board is not eligible to sit on a panel for an application relating to a patient if the member

- (a) is the patient's spouse or common-law partner;
- (b) is related by blood or marriage to the patient;
- (c) is a psychiatrist or a physician who is treating or has treated the patient;

<sup>10</sup> See for example, *Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] 2 S.C.R. 817.

<sup>11</sup> R.S.A. 2000, c. M-13, s. 36.

<sup>12</sup> S.S. 1984-85-86, c. M-13.1, s. 32(6).

<sup>13</sup> C.C.S.M. c. M110, s. 49(8).

<sup>14</sup> S.N.L. 2006, c. M-9.1, s. 63.

- (d) is an officer, employee or staff member of the psychiatric facility in which the person is being treated;
  - (e) is a lawyer who is acting for or has acted for the patient or the psychiatric facility in which the person is being treated; or
  - (f) has a close personal or professional relationship with a person referred to in clause (a) to (e).
- (2) Where there is a reasonable apprehension of bias, a member of the Review Board shall remove himself or herself from the panel.
- (3) A member of the Review Board who has sat on a *Criminal Code* (Canada) review board hearing for a patient shall not sit as a member on a panel of the Review Board for that patient.

In *Equality, Dignity and Inclusion* Froese stated that Article 13 of the UN CRPD requires state parties to ensure that persons with disabilities have effective access to justice on an equal basis with others, which includes the right to a fair hearing by an independent and impartial tribunal.<sup>15</sup> She criticizes the BC *Mental Health Act* for its lack of “provisions relating to persons who are not eligible to be [Mental Health Review Board] members or sit on a particular review panel to avoid any concerns about actual or a reasonable apprehension of bias.”<sup>16</sup> Froese also observed that it is preferable that the community member slot of a review panel is a person living with a mental illness.<sup>17</sup> The BC *Mental Health Act*, however, does not set out any qualifications or expertise for the community member, such as lived experience with mental illness. Individuals appointed to the community member slot have varying backgrounds, but most have some sort of connection to the health care or social service providing professions, such as psychiatric nurses or social workers.

## REPRESENTATIVES REPORTED

### Physician with Non-Practising Status Acting as Community Member

In recent years, there have been physicians who do not have active practising status acting as the community member in review panels. For instance, when a psychiatrist had been serving as a physician panel member, but retired as a psychiatrist, he subsequently sat on review panels as a community member. Several representatives had represented a client in a hearing in which the community member slot of the panel was filled by a physician with non-practising status. Many representatives with these experiences reported that it was just like having a panel with two physicians on it. Non-practising physicians in the community member slot were referred to in the hearing with the title of “doctor”—eg. “Dr. Smith”. Representatives pointed out that individuals with training and experience as a physician bring a physician’s perspective to the panel. Some representatives reported that having someone with medical training in the community member slot influenced the kind of questions they asked. One representative explained that these individuals often demonstrated how much medical knowledge they have in how they ask their questions by, for example, making references to medical literature. Others said that since they tended to

<sup>15</sup> British Columbia, *Equality, Dignity and Inclusion: An Evaluation of British Columbia’s Mental Health Laws, Policies and Service Standards*, by Beverly Froese, in Report to the Law Foundation of British Columbia (Victoria: 31 March 2017), at 35.

<sup>16</sup> *Ibid* at 46.

<sup>17</sup> *Ibid* at 45.



focus on medical issues, the questions were quite different in nature than the questions a community member usually asks.

Some representatives said that in their experience physicians on the review panel tended to be more likely to agree with, and be more deferential to, the treating psychiatrist. In the words of one representative, having a physician in the community member slot “loads the deck against the client”. Others who had experience with a panel with a non-practicing physician in the community member slot were of the view that it did not impact the panels negatively because the individual panel members acting this way applied the criteria conscientiously. However, most representatives pointed out that regardless of the efforts of the individual panel member, these kinds of appointments thwart the legislative intent behind constructing a panel with three different skill sets and perspectives.

*“If there’s a method, if there’s meaning to the composition of the panels under the legislation, it’s a fair assumption that the legislature wants someone who is legally trained, somebody who brings a medical perspective, and somebody who brings a general community perspective. If you have somebody who is trained as a physician who technically doesn’t meet the criteria for physician under the Act because they’re not paying their dues, they’re not a practicing member, and sit as a community member, they’re still bringing a medical perspective. So you now have two people bringing a medical perspective.”*

### Inadequate Protections Against Panel Member Bias and the Apprehension of Bias

Representatives who had been representing clients at review panel hearings for several years observed that in the past the Mental Health Review Board had much better practices to protect against bias or the apprehension of bias. For instance, the Board used to inform detainees and their legal representatives of the composition of their panel two days before the scheduled hearing. Representatives explained that the Board was then quite responsive in removing a panel member when an objection was raised to panel members on the grounds of apprehension of bias. However, the Board has stopped its practice of informing detainees and their legal representatives of the composition of the panel in advance of the hearing, which means detainees do not have the necessary information to form an objection about panel members until a hearing begins and the identity of the panel members is discovered. It is very difficult for detainees to raise an objection regarding panel member bias at the beginning of their hearing because even if it succeeds, an adjournment to arrange for another hearing with different panel members means prolonged detention without a hearing for the detainee.

Representatives reported that the most common concern about bias and the apprehension of bias arose from the same members sitting on multiple hearings in a row for the same detainee. Again, representatives reported that in the past the Board used to be careful not to assign the same panel members across multiple hearings for the same client, but in recent years repeat panel member appointments had become quite common. The Board makes efforts to try to avoid appointing the same panel members across multiple hearings for the same detainee, however, the Board is currently short of tribunal members.<sup>18</sup> Another reason for the increase in repeat panel members was a cost-saving mechanism that the Board recently put in place. The Board has to pay travel expenses for the members who have to travel more than 32kms to a hearing, so by appointing the same members who live in close proximity to the detaining facility the Board saves money on travel reimbursements.<sup>19</sup>

<sup>18</sup> Interview of Mental Health Review Board Acting Chair [15 February 2017].

<sup>19</sup> *Ibid.*

## IN THE WORDS OF THE LEGAL REPRESENTATIVES:

A representative reported that she represented a detainee who had lost three hearings in a row with the same panel member on the panel at all three hearings. The panel member commented to the detainee “so this is three strikes for you”.

Representatives who had experience with representing detainees who had the same panel member appointments across multiple hearings reported that detainees can feel like they’re not getting independent hearings when they see the same panel members over and over. Repeat panel members also raise concerns about whether panel members are solicitously guarding against the temptation to rely on evidence from past hearings, rather than restricting their analysis to the evidence introduced at the present hearing. For instance, one representative reported that she represented a detainee in a hearing with a review panel member who had sat on multiple panels for the detainee who asked the client, “but there was something else to that wasn’t there?” The clear implication was that he was recalling evidence from a previous hearing even though it had not formed a part of the evidence at the current hearing. Another representative reported that she represented a detainee who had lost three hearings in a row with the same panel member on the panel at all three hearings. The panel member commented to the detainee “so this is three strikes for you”.

Besides the issues with the same panel members being appointed to multiple hearings for the same detainee, representatives reported concerns about bias and apprehension of bias because of a connection between panel members and the parties. For instance, one representative reported that she represented a client in a hearing in which the physician panel member and the treating physician presenting the detaining facility’s case for detention were having a “friendly chat” during a recess, which clearly indicated that the two doctors had a friendship outside this professional setting. Another representative reported a review panel hearing where the physician on the panel had been the detainee’s treating physician in the past, something explicitly prohibited by several other Canadian mental health statutes.

## CONCLUSION AND RECOMMENDATIONS

According to the *Mental Health Act*, review panels must be composed of a tripartite panel of an individual with legal training, an individual with medical training, and an individual who is neither a medical practitioner or a lawyer. The practice of physicians without active practising status acting as community members to the Mental Health Review Board flies in the face of this legislative intent and representatives reported several tangible consequences of conducting a review panel with two members with medical training. Although the Minister of Health has been responsible for appointing Mental Health Review Board members until recently, over the course of this research project the responsibility for the Mental Health Review Board has been transferred to the Ministry of Attorney General. The Ministry of Attorney General should ensure that there is a sufficient pool of Mental Health Review Board members appointed whose expertise reflects the legislative intent of tripartite panels. The [Mental Health Review Board](#) should stop the practice of composing review panels with physicians without active practising status acting as community members of the panel.

## SUMMARY OF RECOMMENDATIONS

### COMPOSITION OF REVIEW PANELS

#### For the BC Government:

- Review and amend the *Mental Health Act* to prioritize the appointment of community members with lived experience of mental illness to the Mental Health Review Board.
- Review and amend the *Mental Health Act* to create protections against conflict of interest, bias, and the apprehension of bias among review panel members.

#### For the Mental Health Review Board:

- Amend the Rules of Practice and Procedures or produce policies or guidelines to address bias and the apprehension of bias among review panel members.

Individuals with lived experience of mental illness have unique expertise that is specifically relevant to a review panel hearing. A review panel with a member who has the qualifications of living with a mental illness could improve the fairness and perception of fairness for detainees while promoting more insightful review panel decisions, a topic discussed in more detail in the following section. The **BC Government** should review and amend the *Mental Health Act* to prioritize the appointment of community members with lived experience of mental illness to the Mental Health Review Board.

The right to an impartial decision maker is a necessary component of a fair hearing. The complete absence of statutory protections against panel member bias and the apprehension of bias in the *Mental Health Act* is unacceptable given the significant *Charter* rights at stake for detainees in review panel hearings. Representatives reported several panel composition issues that raise significant concerns for bias and the apprehension of bias, including the appointment of the same panel members to multiple consecutive panels for the same detainee and review panels that took place despite connections between panel members and the parties. The Mental Health Review Board's current failure to disclose panel members in advance of the hearing precludes detainees and their legal representatives from raising bias objections until the panel has begun, forcing detainees to choose between making an objection that could prolong their detention or proceeding with a review panel that they perceive as biased.

The **BC Government** should review and amend the *Mental Health Act* to create protections against conflict of interest, bias, and the apprehension of bias among review panel members.

Regardless of legislative reform, the **Mental Health Review Board** should amend its Rules of Practice and Procedures or produce policies or guidelines to address bias and the apprehension of bias among review panel members, which as a minimum, should include:

- A process for informing detainees and their legal representatives of the composition of the review panel with sufficient time to permit an objection on the grounds of bias or the apprehension of bias to be raised and addressed without disruption to scheduled hearings;
- The factors the Chair will take into account in deciding an objection on the grounds of bias or the apprehension of bias;
- Protections against the same members being appointed to multiple consecutive panels for the same detainee whenever possible; and
- Clear instructions to members who sit on multiple panels for the same detainee to only consider evidence presented at the current hearing.

## MENTAL HEALTH REVIEW BOARD FUNDS THE DETAINING FACILITY TO PARTICIPATE IN THE REVIEW PANEL, BUT NOT THE DETAINEE

Although not set out in the *Mental Health Act*, the *Mental Health Regulation*, or the Mental Health Review Board Rules of Practice and Procedures, the Mental Health Review Board funds detaining facilities to participate in review panel proceedings by compensating the treating physician for preparing expert medical evidence and presenting the state's case for detention at the hearing.<sup>20</sup> The Mental Health Review Board will not fund any of the expenses detainees could incur by participating in the review panel hearings.<sup>21</sup> For example, the Board will not provide detainees with funds to hire a lawyer to represent them at a hearing, reimburse witnesses for travel expenses, or retain an independent physician to conduct an examination and present medical evidence at a hearing.

### REPRESENTATIVES REPORTED

Most representatives were unaware that the Mental Health Review Board pays for detaining facilities to send case presenters to review panels. However, it has a clear impact on review panel hearings. For example, representatives pointed out that when one party to a legal proceeding presents expert medical evidence the other parties typically present their own countering expert evidence. However, detainees usually do not have the resources to compensate an independent medical expert to conduct an examination and prepare a report to present medical evidence at review panel hearings. As a result, the parties before the review panel have unbalanced access to expert evidence — the detaining facility can present expert medical evidence, but the detainee may not be able to afford to.

The parties before the review panel have unbalanced access to expert evidence — the detaining facility can present expert medical evidence, but the detainee may not be able to afford to.

Additionally, in discussing the reports to the review panel generally prepared by treating psychiatrists for the hearing, several representatives observed that it seemed like fewer and fewer psychiatrists were writing these reports but it was unclear why. Another representative reported that a psychiatrist told her that a former Mental Health Review Board Chair told him not to prepare a written report because the Board would no longer pay for his time in preparing it, but she expressed that the psychiatrist must have misunderstood. This is in fact easily explained. Under pressure from the Minister of Health to decrease the budget for review panels, the Mental Health Review Board Chair recently did decrease the amount of money paid to case presenters for their time and suggested that case presenters stop preparing written reports for the panel.<sup>22</sup> Limiting the amount of compensation for treating physicians to prepare reports to the review panel means that reports to the panel are of poorer quality and the panel has less information for adjudication.<sup>23</sup>

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<sup>20</sup> *Ibid.*

<sup>21</sup> *Ibid.*

<sup>22</sup> *Ibid.*

<sup>23</sup> *Ibid.*

## SUMMARY OF RECOMMENDATIONS

### ASSYMETRICAL FUNDING OF PARTIES

For the Mental Health  
Review Board:

- **Stop the practice of funding detaining facilities to prepare and present expert evidence and participate in review panels or start providing equivalent funding to detainees.**

## CONCLUSION AND RECOMMENDATIONS

For a tribunal to function as an independent and impartial decision maker, it must treat all parties that appear before it in a fair and equivalent manner. It is inappropriate for the Mental Health Review Board to fund detaining facilities to prepare and present expert medical evidence and participate in the hearing when it does not provide any funding to detainees to obtain expert medical evidence or participate in the hearing. The asymmetrical funding of parties who participate in review panel proceedings has a significant detrimental impact on a detainee's right to a fair hearing.

There are a variety of structures for compensating physicians for examining individuals and preparing medical evidence in administrative proceedings that do not depend on tribunal funding. For example, the British Columbia Medical Association compensates physicians for the time involved in examining patients and generating reports in accordance with a publically available fee schedule.<sup>24</sup> This report documents numerous examples of the Mental Health Review Board taking cost saving measures that compromise the fairness of review panel proceedings for detainees. The rule that prohibits detainees who have cancelled a hearing from requesting a hearing until the next certification period and the practice of assigning repeat review panel members to the same detainee's hearing to reduce travel expenses are examples of cost saving mechanisms that jeopardize the rights of detainees. The Mental Health Review Board's limited resources currently expended on funding detaining facilities to participate in, and present medical evidence at, review panels would be better allocated to improving hearing fairness.

Conversely, if the Mental Health Review Board continues to fund detaining facilities to participate in review panels by compensating physicians to prepare a medical report and attend the hearing, it could address the discrepancy by providing equivalent funding to detainees. Detainees could benefit immensely from funding to participate in review panels to cover the expenses involved in preparing a case for discharge. Providing funding to enable detainees to obtain and present medical evidence in their case would vastly improve the current imbalance of expert medical evidence at the hearings and present a more fulsome record for the review panel in their adjudication. The **Mental Health Review Board** should either stop its practice of funding detaining facilities to prepare and present expert evidence and participate in review panels or start providing equivalent funding to detainees.

24 See, for instance, Doctors of BC, "Revised Fees for Uninsured Services Effective April 1, 2016\*", online: <[https://www.doctorsofbc.ca/sites/default/files/public\\_uninsured\\_services\\_2016apr01.pdf](https://www.doctorsofbc.ca/sites/default/files/public_uninsured_services_2016apr01.pdf)>.

## PROCEDURAL FAIRNESS AT HEARINGS

It is a fundamental legal principle that when a decision is being made that impacts an individual's rights and interests, the procedure that the decision maker uses must be fair. Procedural fairness considers the process followed to reach the decision, rather than the outcome of the decision itself. A legal procedure is fair when parties are given adequate notice that a decision is going to be made, parties have the opportunity to be heard and make representations before the decision is made, consistent rules are applied to each individual, the decision maker provides reasons for the decision made, and parties have an opportunity to seek review or appeal of the decision.

The level of procedural fairness required in a particular process varies depending on the context. The greater the effect the decision has on an individual, the greater the need for procedural fairness.<sup>25</sup> It is challenging to think of a legal proceeding in Canada that has a greater impact on an individual than detention in BC's mental health system. Like other legal proceedings that consider detention, such as criminal or immigration detention, a review panel proceeding decides whether an individual will lose the liberty guaranteed by the *Charter*. However, in *BC Mental Health Act* detention also results in forced psychiatric treatment, which engages the *Charter* right to life, liberty, and security of the person. The *Charter* requires that legal proceedings regarding mental health detention be conducted with a high degree of procedural fairness.

While procedural fairness is constitutionally required in review panel proceedings, there is a growing body of evidence that demonstrates that procedural fairness may also have a therapeutic value for individuals in mental health detention. Therapeutic jurisprudence is an interdisciplinary approach to law reform that sees potential benefit in the exercise of legal rights and the law itself as potentially therapeutic. There is a significant risk that the coercion inherent in mental health detention can diminish any potential efficacy or benefit of hospitalization and psychiatric treatment, therefore creating counter-therapeutic effects for people with mental health problems. Therapeutic jurisprudence research has found that granting patients subject to mental health detention and involuntary psychiatric treatment the opportunity to be heard in a fair procedure can counter this risk by minimizing perceptions of coercion and improving therapeutic relationships with health care providers.<sup>26</sup>

## REPRESENTATIVES REPORTED

While this section discusses procedural fairness at review panels, it is important to note that many pre-hearing issues can significantly impact the fairness of the hearing itself. For instance, many representatives identified the failings of detaining facilities in conducting pre-hearing disclosure as presenting significant procedural fairness problems at the hearing. When the detaining facility has not made adequate pre-hearing disclosure of its case, detainees and their legal representatives are deprived of the opportunity to know and prepare for the case they need to meet at the hearing. Pre-hearing issues are discussed in more detail in section 5 | [Scheduling and Preparing for a Review Panel Hearing](#).

<sup>25</sup> *Suresh v. Canada (Minister of Citizenship and Immigration)*, 2002 SCC 1 at para. 118.

<sup>26</sup> See for instance, Bruce J. Winick "A Therapeutic Jurisprudence Approach to Dealing with Coercion in the Mental Health System" (2008) 15:1 Psychiatry, Psychology and Law 25.



## Attendance of Observers or Support People at Hearings

Unlike many legal proceedings, review panel hearings are closed to the public. Section 25(2.5) of the *Mental Health Act* states that unless the review panel orders otherwise, the hearing must be held in private. Given the negative stigma that our society still attaches to people with mental health diagnoses, it is important that the privacy of detainees in review panel hearings is respected. However, detainees sometimes want a family member or friend to attend a review panel with them to provide emotional support. The presence of a support person can go a long way to improving the review panel experience for detainees. Other observers may want to attend a hearing for the purposes of training, such as new panel members, health care and social service providers, or legal representatives. The Mental Health Review Board Rules of Practice and Procedures state:

- 16.1 Only the case presenter and the patient with their respective advocates, if any, are authorized to attend the hearing as it must be held in private unless the review panel otherwise orders. Observers may be authorized by the review panel to attend after consideration of submissions from the patient, case presenter and/or their advocates.

Representatives reported that the practices of review panel members vary in responding to detainee requests to have a support person present in a hearing. Several representatives had experiences with review panel members permitting support people to attend once the members had ensured that the detainee wanted the individual present. Others reported that review panel members excluded support people detainees wanted to be present without justification. Some representatives who have been representing detainees for many years observed that the Mental Health Review Board used to respect the wishes of detainees in permitting a support person to attend the hearing, but recently seemed to be excluding support people contrary to detainees' wishes. Some representatives reported being told by review panel members that there was a recent change in Mental Health Review Board internal policy and members were instructed not to permit any support people or observers to attend hearings. The Mental Health Review Board in fact did recently instruct panel members not to permit support people or observers to attend hearings after a few troubling incidents at hearings where detaining facilities brought a disruptively large number of staff into hearings for training purposes.<sup>27</sup> However, that change in policy is not reflected in any public documents and the exclusion of a detainee's support person is not necessary to address the problematic practice of some detaining facilities disrupting hearings with large numbers of observing staff.

Given the lack of clear policy on observers and support people attending hearings, it is unsurprising that several representatives still reported experiences with review panel members permitting observers in training from detaining facilities to attend the hearing who the detainee did not want to be present. Representatives reported that additional facility staff attending the hearing can make the detainee feel uncomfortable, but they often felt too intimidated or concerned about appearing uncooperative to express those feelings of discomfort. In a compelling example of this conundrum, one representative reported an experience with a treating physician who wanted to bring another physician in to observe the hearing, but when the legal representative asked the detainee, he said that he was upset about the idea and his feelings were, "this isn't a fish bowl, I'm not an experiment, this is my life and I don't want anyone in there that doesn't have to be". The legal representative informed the panel and the treating physician of his client's wishes and the panel excluded the observing physician, but shortly after that the

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<sup>27</sup> Interview of Mental Health Review Board Acting Chair [15 February 2017].

legal representative found the treating physician speaking with the detainee in the hallway about how difficult he was being to try to convince him to allow the additional observing physician to attend.

The line between individuals who are present to provide support and witnesses who are present to provide evidence has not always been respected by review panel members. Representatives reported that review panel members are generally careful to exclude witnesses from the hearing room prior to providing their testimony to ensure that their evidence is not influenced by the evidence they hear from others. However, several representatives reported that review panel members had asked non-witnesses questions, such as observers or support people who had been present throughout the entire hearing. One representative said that when she objected to this procedural fairness violation, the information solicited from the non-witness was omitted, however, two other representatives reported that objections were overruled despite the fact that it had been discussed and decided at the outset of the hearing that the individual was present to provide support, not evidence. Some representatives reported that as a result, they now feel obligated to warn detainees who want to bring in a family member or friend for support in the hearing that there was a chance that the review panel members would try to question them. This can function as a deterrent for detainees to get the support they need to mitigate the stress of hearings and can create even more barriers for family members and friends who are trying to be involved with a loved one's recovery process.

### Lack of Clarity in Hearing Procedures

The *Mental Health Act*,<sup>28</sup> *Mental Health Regulation*,<sup>29</sup> and the Mental Health Review Board Rules of Practice and Procedures set out some procedures for review panel hearings.<sup>30</sup> However, representatives reported that review panel hearing procedures varied widely depending on which member chairs the hearing and it seemed that each chair had her own way of conducting the hearing. Several representatives expressed a desire for more clarity in the form of rules, guidelines, practice directions, or policies to create more consistency and structure in hearing procedures. A common example that representatives gave of variable hearing procedures was the issue of opening and closing statements. In legal proceedings, both parties typically have the opportunity to make a brief opening statement that sets out what evidence and arguments the party intends to introduce in the hearing. These statements function as a "road map" for decision makers to know how the parties intend to organize their case. At the conclusion of a hearing, both parties typically have the chance to summarize their case and present their legal arguments through closing statements.

The Mental Health Review Board Rules of Practice and Procedures are silent on the topic of opening statements, but state that the "review panel shall give the patient or his/her advocate and the case presenter an opportunity to make a final submission in support of the decision or order they want the review panel to make."<sup>31</sup> Although several representatives reported being given an opportunity to make a brief opening statement, other representatives had experiences with review panel chairs who would not permit an opening statement at all. Others reported that some chairs permitted opening statements but they were interrupted and told that their opening statement was not appropriate, even when following a typical format by laying out what evidence would be presented in the hearing through testimony or documents.

28 See for instance, s. 25.

29 See for instance, s. 6.

30 See for instance, r. 14—17.

31 *Ibid*, r. 14.4.

Representatives reported that chairs generally permit both parties to make closing statements, however, this was not universally respected in every hearing.

Another hearing procedure issue raised by representatives is that the review panel does not require witnesses to make an oath or affirmation before providing testimony. Rule 14.2 of the Mental Health Review Board's Rules of Practice and Procedures states that review panels may require that evidence be given under oath or affirmation. However, representatives universally reported that they had never seen a case presenter, detainee, or any other witness asked to make an oath or affirmation before providing testimony. Representatives who represent clients in other administrative tribunal or court hearings observed that this was an unusual departure from other legal proceedings where witnesses are required to make an oath or affirmation before providing testimony.

### Procedural Fairness Issues Raised by Review Panel Member Conduct

After the parties to an administrative proceeding have concluded presenting their evidence, it is typical for decision makers to follow up with any questions that were not addressed during the parties' case presentations. Review panel members have the authority to ask questions of the parties before the panel, namely, the detaining facility's case presenter and the detainee. However, unlike the parties to a proceeding, review panel members are also responsible for ensuring that the procedures followed in a hearing are fair and observe the principles of natural justice. Representatives reported the following examples of inappropriate questioning or conduct by review panel members that jeopardized the fairness of hearings:

- Panel members repeatedly asked the same question that had already been answered several times in a way that made it clear that they wanted to hear a specific answer;
- Panel members started questioning the detainee before the legal representative had the opportunity to take their client through direct examination. Legal representatives reported that when panel members do this they are usually asking the same questions that the legal representative was going to cover in direct examination and are therefore needlessly interrupting the detainee's case presentation;
- Panel members tried to rush or cut off detainees and their legal representatives in presenting their case. For example, several legal representatives reported being told to hurry questioning or arguments by panel members who said that their parking was going to expire or they had a plane to catch, even though the hearing had only taken 1.5 or 2 hours; and
- Panel members asked leading questions that contained the answer and made it seem like they are trying to assist the detaining facility in making the case for detention. For example, the panel members asking the treating physician to agree with a proposition from medical research or a physician panel member attempting to conduct a mental status exam of a detainee during a hearing.

Representatives also reported some review panel members asked questions that challenged a detainee's reasons for requesting a hearing and demonstrated a lack of understanding of detainee's right to a review panel. For example, representatives reported panel members asking detainees questions like "don't you understand that the doctors are here to help you?", "isn't extended leave good enough for you?", "if you are going to be a voluntary patient, why are you here", or "what's wrong with just being certified for a few more months." An individual who is willing to engage with treatment is suitable as a voluntary patient and

## IN THE WORDS OF THE LEGAL REPRESENTATIVES:

**“I don’t think the client should have to justify why they are there for a hearing... It shows a lack of appreciation about why these panels sort of exist ... a lack of appreciation of why somebody would just want to have some autonomy... It’s sort of an acknowledgement that you don’t really have a difference in rights whether you’re voluntary or involuntary in the sense that you have to do what the psychiatrist says regardless....”**

therefore does not meet criteria for continued detention. While the review panel is entitled to evaluate a detainee’s contention that he will continue with treatment, it is an error of law for a panel member to conflate requesting a panel with unwillingness to engage with treatment. One representative explained the unfairness to a detainee in questioning her motivation for requesting a review panel as follows:

*“I don’t think the client should have to justify why they are there for a hearing... It shows a lack of appreciation about why these panels sort of exist ... a lack of appreciation of why somebody would just want to have some autonomy... It’s sort of an acknowledgement that you don’t really have a difference in rights whether you’re voluntary or involuntary in the sense that you have to do what the psychiatrist says regardless...”*

Representatives also observed review panel members acting in a manner that was dismissive or disrespectful of detainees during hearings. The most common examples reported were questions, comments, or behaviour that conveyed incredulity about a detainee’s evidence. For example, one representative recounted that when a detainee testified that the psychotropic pharmaceutical agent she was being administered caused intermittent tremors in her hands one panel member audibly commented to another panel member “I don’t see her shaking”. Other representatives reported more subtle condescending acts, such as asking detainees unnecessarily harsh or sarcastic questions, eye rolling or negative facial expressions in response to a detainee’s evidence, or smiling or exchanging “knowing looks” with other panel members or the case presenter. Some legal representatives also reported being told by panel members not to advance certain evidence or arguments or that the arguments they made on behalf of a detainee were “ridiculous”. While review panel members are clearly entitled to make negative credibility findings and reject the evidence or arguments of any party in their decision, representatives reported that when members engage in this sort of conduct during the hearing it can make detainees feel like they did not get a fair hearing.

Representatives recounted experiences with review panels in which the members intimated that they had already decided to detain the individual before the parties had completed presenting their evidence in the hearing. Sometimes this was quite obvious, for example, one representative observed a chair tick off the box on the decision form to continue detention and begin writing their reasons for detention during a recess in the middle of a hearing. Others reported more subtle behaviour that indicated that members viewed detention as a forgone conclusion that did not require serious deliberation. For example, one representative reported that when they returned to the hearing after the panel concluded their deliberation the chair said, “don’t even bother sitting down, it’s a no” and she had to insist that they sit down to hear the decision. Another representative reported that they had experienced review panels in which the chair announced at the conclusion of the hearing that the panel would return with their decision in 10

When panel members engage in this sort of conduct it can make detainees feel like they did not get a fair hearing.

minutes without checking with the other panel members. Since a review panel has up to 48 hours to issue its determination and each panel member may vote individually, informing a detainee that deliberation will take 10 minutes is a clear indication that the conclusion is so obvious that no one on the panel could have a different view and very little time is required for deliberation.

Finally, representatives reported examples of questions and comments made by review panel members that indicated a lack of education and awareness of different cultures or the lived experiences of people of a different race, class, or gender. Representatives reported that the review panel often does not seem to understand or give weight to a detainee's evidence that they will use spiritual or cultural sources of support as part of their treatment and recovery, for example, when First Nations detainees express that they want to have elders involved in their treatment plan. One representative reported an example of three white panel members who interpreted a First Nations woman's reference to her aunts as a source of support in her discharge plan as a delusion because the woman did not have biological aunts. A representative reported representing a female detainee at a hearing who had recently escaped a violent male partner, but was still struggling with the traumatic impacts of the abuse. A male panel member asked her multiple questions about why she had not tried to improve her safety by leaving her violent partner sooner, which demonstrates ignorance not only of the significant structural barriers that prevent women from leaving violent partners, but also of the fact that women are actually at a statistically elevated risk of violence from abusive men when they leave.<sup>32</sup>

### Inappropriate Physical Location for Review Panel Hearing

Review panel hearings for inpatient detainees are held in a conference room or meeting room at the detaining facility. The Mental Health Review Board Rules of Practice and Procedures do not address requirements for the physical location for hearings. Several representatives reported that the physical location that detaining facilities choose to schedule review panels in is often inappropriately small. Numerous people can be present at review panel hearings: three panel members, the detainee, the detainee's legal representative, at least one, and sometimes two, case presenter(s), support people, witnesses, an interpreter if the detainee speaks English as a second language, detaining facility staff in training, legal representatives in training, and review panel members in training. When a detaining facility schedules a review panel in a room that is not large enough to accommodate the number of people involved in a hearing, it can create an extremely cramped hearing procedure. Some representatives reported that there

<sup>32</sup> Canada, Department of Justice, "Violence Perpetrated by Ex-Spouses in Canada", by Research and Statistics Division (Ottawa: Department of Justice, 2014), online: <[http://www.justice.gc.ca/eng/rp-pr/cj-jp/fv-vf/rr14\\_03/rr14\\_03.pdf](http://www.justice.gc.ca/eng/rp-pr/cj-jp/fv-vf/rr14_03/rr14_03.pdf)>; Statistics Canada, "Measuring violence against women: Statistical trends" by Canadian Centre for Justice Statistics in *Juristat* (Ottawa: Statistics Canada, 25 February 2013) at 57.

was sometimes insufficient space for review panel members, case presenters, and the legal representative to put records or binders on the table or take notes.

Insufficient space to conduct a hearing can create procedural fairness issues. For example, one representative pointed out that when you and your client are sitting directly next to the case presenter who is responsible for presenting the state's case for detention he can see every interaction and note exchanged between the detainee and her representative. Not only can this be quite intimidating for the client, there is also a very real possibility that the case presenter will see notes that are legally privileged or see cross examination questions written down before they have been asked. Several representatives also pointed out that inappropriate physical locations can contribute to an informal atmosphere that makes individuals treat the hearings casually, rather than an important legal proceeding. For example, one representative reported that a detaining facility had tried to move a review panel hearing to a family room which was furnished with couches and other recreational items, not with a table to sit at. Several representatives were of the view that the Mental Health Review Board was too deferential to detaining facilities on the issue of the physical location of the hearing.

Representatives were not asked about the use of teleconference or videoconference technology in review panel hearings because such technologies are rarely used. However, a few representatives who had experience representing detainees at review panels that used such technology volunteered observations in discussing hearing logistics. For example, these representatives had conducted review panels for detainees in rural communities in which one of the three review panel members participated in the hearing via videoconference because there were insufficient review panel members in that community. The representatives with experiences of review panels that used teleconference or videoconference technology expressed concern that the use of this technology had negative impacts on review panels that could jeopardize the fairness of the hearing. For instance, representatives reported that the flow of direct and cross-examination could be interrupted by connection failures and that even when the technology was functioning it was challenging for review panel members to engage in the credibility assessments necessary to resolve contradictory evidence. In addition, since detaining facilities often fail to fulfill disclosure obligations in advance of the hearing, the panel members participating by videoconference often do not have access to the documentary evidence that the facility presents to the panel. Finally, representatives pointed out that the use of technology can contribute to the anxiety detainees experience at review panel hearings, particularly for individuals who have feelings of paranoia related to the use of technology.

## CONCLUSION AND RECOMMENDATIONS

The Mental Health Review Board has not developed sufficient rules, policies, guidelines, or practice directions to guide review panel members in conducting consistent and fair hearings. In addition, the training of review panel members is inadequate. Review panel members require training on a vast array of topics, including the *Charter* rights at stake for detainees and the *Charter* principles that must inform their decisions, the statutory and regulatory framework of *Mental Health Act* detentions, the responsibility for conducting hearings with procedural fairness, how to receive and weigh evidence and how to respond to objections on the admissibility of evidence, and how to issue written reasons that inform the parties why, how, and on what evidence the panel members reached their decisions and permit review by a court. One to two days of training is simply not a sufficient amount of time to equip review panel members to fulfill their duties as tribunal members who adjudicate the deprivation of an individual's liberty, especially



## SUMMARY OF RECOMMENDATIONS

### PROCEDURAL FAIRNESS AT HEARINGS

For the Mental Health Review Board:

- Improve initial training and ongoing professional development for review panel members.
- Establish clear hearing procedures in which parties are permitted a full opportunity to present their case.
- Address the issue of observers and support people attending review panel hearings.
- Establish parameters for detaining facilities to ensure that hearings take place in appropriate physical locations.

For the Ministries of Health and Mental Health and Addictions in conjunction with the health authorities:

- Create standardized provincial policies and training that address the attendance of health care providers as observers at review panel hearings and appropriate physical locations for scheduling review panel hearings.

in light of the significant consequences that flow from detention, such as forced psychiatric treatment and placement in restraints or seclusion.

As a result of inadequate training and insufficient published policies, guidelines, or practice directions, representatives reported that review panel procedures are inconsistent and vary depending on which members the review panel is composed of. Reports from representatives demonstrate that there is no clear policy or practice regarding the attendance of observers or support people at hearings. Representatives raised several concerns in relation to panel member conduct that jeopardizes the procedural fairness of hearings and makes detainees feel as if they have not had the opportunity to be listened to in a dignified and respectful proceeding. Finally, the logistics of a review panel, such as hearings being scheduled in inappropriately small rooms or the reliance on teleconference or videoconference technology, have negative impacts on hearing fairness. There is no doubt that many of the procedural fairness issues that exist in review panel proceedings today have been exacerbated by the years of inadequate legal aid funding to provide detainees with a legal representative who is equipped to make objections and insist that procedural fairness is observed.

The **Mental Health Review Board** should take steps to improve the consistency and fairness of review panel hearing procedures, which as a minimum, should include:

- An improved initial training process and ongoing professional development for review panel members;
- Amendments to the Rules of Practice and Procedures or the development of policies, guidelines, or practice directions in consultation with stakeholders to establish clear hearing procedures in which parties are permitted a full opportunity to present their case;
- Amendments to the Rules of Practice and Procedures or the development of policies, guidelines, or practice directions in consultation with stakeholders to address the issue of observers and support people attending review panel hearings; and
- Amendments to the Rules of Practice and Procedures to establish parameters for detaining facilities to ensure that hearings take place in appropriate physical locations.

The **Ministries of Health and Mental Health and Addictions should work in conjunction with the health authorities** to create standardized provincial policies and training that address the attendance of health care providers as observers at review panel hearings and appropriate physical locations for scheduling review panel hearings.

## REVIEW PANEL DECISIONS

Review panels have 48 hours to determine whether the detention of the patient should continue and must issue reasons for the decision within 14 days after the determination is made.<sup>33</sup> Typically review panels engage in deliberation when a hearing ends and call the parties back into the hearing room to communicate their decision once it has been reached. The detainees or their legal representatives are sent the written reasons for the decision within a few days. Review panel decisions are never published.

The Mental Health Review Board has no public rules or policies that address how reasons are written or what review of reasons the Chair engages in. The internal practice of the Mental Health Review Board is that the chair of the panel writes the reasons of a majority or unanimous decision and each member writes their own dissenting reasons.<sup>34</sup> The internal practice with respect to reviewing written reasons varies depending both on which member wrote the reasons and the outcome of the decision. The Mental Health Review Board Chair reviews all draft written reasons of physician panel members and community panel members before publication, but does not apply the same standard to lawyer panel members.<sup>35</sup> The Chair also asks to review all draft reasons for discontinuation of detention, but does not review the draft reasons for continuing detention.<sup>36</sup> Lawyer members, who receive 1.5 to 2 days of training before they begin adjudicating hearings, are given more training on issuing written reasons than physician members and community members, who only receive 1 day of training before they begin adjudicating hearings.<sup>37</sup>

The most obvious reason for not publishing review panel decisions is that it protects the privacy interests of *Mental Health Act* detainees and their personal support network. This privacy is important given the significant stigma and discrimination people with mental disabilities are still exposed to. However, other mental health tribunals address this concern by anonymizing the decisions on publication, including comparable mental health tribunals in other Canadian jurisdictions. For example, the Ontario Consent and Capacity Board publishes all its reasons for decision using initials instead of full names for individual parties and their family members and omitting the workplace or employer's name and other personal identifiers.<sup>38</sup>

In *Increasing Understanding*, Cheung discusses the potential benefits of publishing review panel decisions as follows:

*Whereas closed, private hearings may protect the patient from stigma, open hearings and a public record of decisions and interpretations increase the transparency and accountability of the system, which may benefit patients' rights into the long term. Being able to consult and cite precedent could help*

There are no published decisions, policies, or guidelines to guide review panel members in interpreting and applying the legal criteria.

<sup>33</sup> *Mental Health Act* s. 25(2.8).

<sup>34</sup> Interview of Mental Health Review Board Acting Chair [15 February 2017].

<sup>35</sup> *Ibid.*

<sup>36</sup> *Ibid.*

<sup>37</sup> *Ibid.*

<sup>38</sup> Consent and Capacity Board, "Board's Reasons For Decision", online: <<http://www.ccboard.on.ca/scripts/english/legal/reasonsfordisions.asp>>.

*patients prepare for hearings, a process that itself can be therapeutic (Wexler 2000). A public record of interpretations would also help the Ministry of Health develop standards that could be applied more consistently throughout the province.*

...

*A potentially beneficial aspect of an open record of hearing decisions, therefore, is that... those writing the review panel decisions may be more inclined to be respectful in their language, thus increasing the therapeutic value of the proceedings.<sup>39</sup>*

## REPRESENTATIVES REPORTED

### Consistency and Predictability of Review Panel Decisions

One of the hallmarks of fairness in any legal proceeding is that the law is applied in the same way to different individuals. Going into a hearing, individuals should be able to expect that the decision will depend on facts and law, rather than who the individual decision makers are. Legal representatives gave mixed responses when asked whether review panel members applied the criteria in the *Mental Health Act* consistently across detainees. Several representatives reported that in their experience hearing outcomes were largely consistent and predictable. However, more representatives were of the view that review panel outcomes were inconsistent, unpredictable, and, to use the words of one representative, “all over the place”. From the perspective of these representatives, the outcome of hearings depends more on who the panel members are than the facts of the individual in front of the panel. Representatives reported that they have observed that some panel members have pre-existing tendencies and it seemed like certain panel members almost never voted to discontinue detention.

Several legal representatives pointed to the complete absence of published reasons or guidelines on interpreting and applying the *Mental Health Act* criteria as a significant barrier to consistency in review panel decisions. Many reported that they have represented detainees with very similar facts and one would be detained and the other would not because of variations in different members’ interpretation of the legal criteria. A common example raised by representatives was the interpretation of what it means to be suitable as a voluntary patient. Some members have applied that criterion to mean that a detainee who is willing to engage in sufficient treatment to prevent substantial mental and physical deterioration is suitable as a voluntary patient and detention is discontinued. In contrast, other members have interpreted anything short of complete endorsement of the opinions and recommendations of the treating psychiatrist to mean a detainee is unsuitable as a voluntary patient and detention is continued. With no published decisions and no guidelines addressing interpretation and application of criteria, these discrepancies will continue to create inconsistent hearing outcomes for detainees.

Some representatives also raised concerns that the individual characteristics of detainees, like race, gender, and class, can influence hearing outcomes. For instance, representatives reported that more affluent detainees were less likely to be detained because they had better access to housing and other sources of support when discharged than poorer detainees. Representatives also reported examples of girls and women being subjected to more paternalistic standards for detention than boys or men, whose liberty interests were more likely to be prioritized. For instance, some representatives observed that girls or women involved in prostitution or who were otherwise being exploited or abused by men were more likely to

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39 Iva Cheung, *Increasing understanding of the British Columbia Mental Health Act: preliminary work* (September 2016) [unpublished] at 60.

be detained for their own protection, while the men engaging in the exploitative or abusive behaviour were not detained. One representative also expressed concern that female detainees who were pregnant seemed to be more likely to be detained for the protection of their fetus or baby once it was born.

### Reliance on Facts Not in Evidence or Insufficient and Unreliable Evidence

It is a basic tenet of procedural fairness that you have a right to hear all the evidence in a legal proceeding and be given an opportunity to respond to it. However, several representatives reported experiences with review panels that referred to facts in decisions that were not presented in evidence in the hearing. Some representatives reported reading references to facts in decisions that were not presented at the hearing on the record and being unable to tell how the panel members came across the information. They speculated that the facts could have come from a panel member who had sat on multiple panels for the same detainee who was recalling information from a previous hearing or that panel members had access to records that were not disclosed to the detainee. Other representatives reported experiences with panel members who had stepped outside of their role as adjudicators and adduced and relied on evidence from their own research conducted after the hearing had concluded without giving the parties an opportunity to respond. Finally, some representatives gave examples of review panel members referring to facts that were clearly errors, for instance, a reference to information that appeared to be from another detainee's hearing or a misunderstanding of the evidence presented at the hearing.

Much more common was the concern about review panels' reliance on insufficient and unreliable evidence. Nearly all representatives raised significant concerns about the vast amount of hearsay evidence admitted in hearings and the weight members accorded to it. In legal proceedings, witnesses are generally only permitted to testify about something they have seen or heard first hand. For example, a psychiatrist could testify about behaviour he had observed a detainee engaging in as an inpatient on a ward. When a witness repeats something that another person saw or heard and told him about, it is hearsay evidence. For example, if a psychiatrist testifies that a family member told him about behaviour she saw a detainee engage in at home before admission, it is second hand information and is therefore hearsay evidence. The rules of evidence in courts generally prohibit the admission of hearsay evidence because second hand information is by nature less reliable and weaker evidence. In addition, when a witness provides hearsay testimony it denies the parties the opportunity to question the person who is the source of the evidence.

Review panels are more informal legal proceedings and take a more relaxed approach to the rules of evidence than those applied in a formal court setting. Rule 17.1 of the Mental Health Review Board Rules of Practice and Procedures states that the review panel may receive and accept information that it considers relevant, necessary and appropriate, whether or not the information would be admissible in a court of law. Representatives reported that detaining facilities often present a large

Nearly all representatives raised significant concerns about the vast amount of hearsay evidence admitted in hearings and the weight members accorded to it.

amount of hearsay evidence to make the case for detention, sometimes even triple or quadruple hearsay evidence that has accumulated in a detainee's chart over prolonged periods of time. Representatives gave examples such as a treating psychiatrist introducing evidence about a detainee's behaviour based on something a family member observed several years ago and told a police officer, who told a nurse, who told the psychiatrist. This kind of evidence has been interpreted and recounted by several different people and is so far removed from its original source that it should not be relied on for the truth of its contents in a legal proceeding.

While representatives recognized that review panels had a more informal approach to the rules of evidence, many observed that review panel members seemed to apply no standards at all to the admission or weighing of evidence. Representatives reported that when they objected to excessive hearsay evidence presented in hearings, they were typically told by review panel members that all evidence would be admitted but hearsay evidence would be given less weight in reaching a decision. However, when the decision was published, members often made reference to the hearsay evidence along with all the other evidence in a way that made it clear that the members had not grappled with the issue of how to weigh unreliable evidence. Several representatives reported that the evidence the review panel admits and relies on would never form the basis for a decision in another legal proceeding. Lawyers who conducted hearings in other administrative settings that also take a relaxed approach to the rules of evidence reported that review panels relied on evidence that other tribunals never would. Some representatives observed that it seemed like review panels had abandoned their role as gatekeepers of evidence.

*"The case presenter's evidence is accorded so much weight and the rules of evidence are so relaxed that eventually they get to almost write the evidence I felt sometimes."*

### Inadequate Written Reasons for Review Panel Decisions

The written reasons for a review panel decision are an integral component of a fair hearing. The reasons allow the parties to know why, how, and on what evidence the panel members reached their decisions. Written reasons should set out the legal question to be answered in the decision, present the evidence raised by the parties, resolve any conflicts in relevant evidence and explain the reasons for resolving the evidence that way, set out the applicable law and policy, apply the law and policy to the facts of the case, and reach a conclusion.<sup>40</sup> This does not mean that administrative decision makers must refer to every piece of evidence or set out every finding or conclusion in the process of arriving at the decision, but the "path" taken by the decision maker to reach its decision must be clear from the reasons.<sup>41</sup> Reasons must be written in a way that allow a court reviewing the decision to understand why an administrative decision maker reached the decision and permit the court to determine whether the conclusion is within the range of acceptable outcomes.<sup>42</sup>

Representatives had serious concerns about the adequacy of written reasons for review panel decisions. Several representatives reported that the quality of written reasons varied greatly depending on the member who wrote them — while some reasons are organized and make clear reference to the legal criteria, others look more like a "stream of consciousness" to use one representative's words. Representatives

40 For a good discussion on adequacy of written reasons among administrative decision makers, see Continuing Legal Education Society of BC, "Self-Governing Professions — 2014 Paper 5.1 Adequacy of Reasons" by Nitya Iyer (Vancouver: CLEBC, April 2014), online: <<http://www.cle.bc.ca/PracticePoints/ADMI/14-AdequacyofReasons.pdf>>.

41 *R. v. REM*, 2008 SCC 51 at para. 24; *Clifford v. Ontario Municipal Employees Retirement System*, 2009 ONCA 670 at para. 29.

42 *Newfoundland and Labrador Nurses' Union v. Newfoundland and Labrador (Treasury Board)*, 2011 SCC 62.

## IN THE WORDS OF THE LEGAL REPRESENTATIVES:

**“I interpret the sufficiency of reasons as an expression from review panel members of their perspective towards patients. If they’re not taking the patient’s evidence into account in their reasons, weighing it and coming down on one side or the other it appears that they’re not even considering it.”**

observed that some written reasons are so generic or lacking in analysis that it would not be possible for the parties or a court on review to understand how the review panel reached its decision. There were three themes consistently raised by representatives in their discussion of review panel reasons: unbalanced references to the parties’ evidence and arguments, failure to adequately weigh and resolve conflicts in relevant evidence, and insufficient legal analysis and interpretation of the law.

First, representatives reported that review panel reasons tend to recount the evidence and arguments raised by the detaining facility, but make little to no reference to the evidence and arguments raised by the detainee. When a decision maker accepts or rejects a party’s evidence or arguments, it is important that the reasons summarize the evidence and arguments presented by both parties and explain how contradictory factual or legal issues were resolved. However, nearly all representatives reported that review panel reasons rely heavily on the detaining facility’s evidence and arguments, but rarely reference a detainee’s evidence or arguments at all, even to say why it was rejected. Representatives reported that on reading a review panel’s reasons, detainees often feel like the review panel did not listen to them. A common example reported was when detainees present a discharge plan with evidence about how they are going to maintain their health and that evidence is not referenced at all in the decision. It appears to detainees that the review panel did not even consider their plan.

*“It all comes down to being heard ... a lot of the frustration and blockage comes from that ... even if people are told they’re wrong, do they feel like they’re being listened to?”*

*“I interpret the sufficiency of reasons as an expression from review panel members of their perspective towards patients. If they’re not taking the patient’s evidence into account in their reasons, weighing it and coming down on one side or the other it appears that they’re not even considering it.”*

*“It’s almost as if the client’s evidence isn’t even worth writing down.”*

Second, representatives reported that review panel reasons often fail to adequately weigh and resolve conflicts in evidence that are necessary to reach a decision. It is common in legal proceedings for two opposing parties to present contradictory evidence and review panels are no exception — the detaining facility’s case presenter often presents evidence that is in direct conflict with the detainee’s evidence. When faced with contradictory evidence that goes to the core of the issue to be decided, decision makers must choose which evidence is preferred and explain the reasons for such preference.<sup>43</sup> However, representatives report that review panel reasons typically summarize the evidence of the detaining facility and then jump to a conclusion on the basis of that evidence without explaining the path taken to reach that conclusion. One representative said that decisions of review panels often look more like a report than a legal adjudication. On the rare occasion when a detainee’s evidence is referenced, panel members usually

<sup>43</sup> *Whyte v. British Columbia (Superintendent of Motor Vehicles)*, 2013 BCCA 454 at paras. 19-20.



just recount the two parties' contradictory evidence and then state a finding of fact without weighing the evidence, making a negative credibility finding, or explaining why they prefer one party's evidence over the other. Several representatives observed that the evidence presented by a detaining facility almost always formed the basis of the findings of fact without any explanation for the reliance.

*"There's a lot of deference showed to the treating doctor. If the doctor says this is the case, the panel seems to take that as, this must be it. The doctor's evidence is almost always preferred without explaining why... Maybe there's a logical reason, but it would be good to know the reason why."*

Finally, representatives reported that review panel reasons often have insufficient analysis applying the law to the facts of the case and interpreting the *Mental Health Act* criteria for detention. For example, it is common for a review panel to conclude that detention must be continued to prevent substantial mental or physical deterioration without interpreting what substantial mental or physical deterioration is or how the individual detainee will substantially deteriorate if detention is discontinued. Many representatives pointed out that when written reasons contain no analysis of why an argument is accepted or rejected, it is very challenging for legal representatives to understand how review panels interpret the law. Representatives advance legal arguments that may gain traction with some panel members, but not others, but with insufficient legal analysis in written reasons, no published decisions, and no guidelines there is no way to build precedents with a shared understanding of how to interpret and apply the criteria. When every legal argument begins and ends in an individual panel, the law can never develop beyond that individual hearing.

As a result, most representatives expressed that publishing anonymized review panel decisions would be beneficial for many reasons. Several representatives were of the view that published decisions would likely result in improvements to the quality of written reasons and consistency among decisions. They also stated it would be beneficial in training new panel members, legal representatives, and detaining facility case presenters. While published review panel decisions would not be binding on future panels, they would create precedents that could advance the interpretation of legal criteria and expose inconsistent interpretations. One representative also pointed out that from the perspective of detainees, a body of published anonymized decisions could help address the impression that review panel decisions are closed, secretive proceedings that target or persecute them as individuals.

## CONCLUSION AND RECOMMENDATIONS

The Mental Health Review Board publishes no policies, guidelines, or decisions to guide review panel members in interpreting and applying the legal criteria in the *Mental Health Act*. In addition, the training of review panel members is inadequate, as previously discussed, and the training on how to make decisions and write reasons is no exception. Review panel members require training on a vast array of topics, including the *Charter* rights at stake for detainees and the *Charter* principles that must inform their decisions, the statutory and regulatory framework of *Mental Health Act* detentions, the responsibility for conducting hearings with procedural fairness, how to receive and weigh evidence and how to respond to objections on the admissibility of evidence, and how to issue written reasons that inform the parties why, how, and on what evidence the panel members reached their decisions and permit review by a court. One to two days of training is simply not a sufficient amount of time to equip review panel members to fulfill their duties as tribunal members who adjudicate the deprivation of an individual's liberty, especially in light of the significant consequences that flow from detention, such as forced psychiatric treatment and placement in restraints or seclusion.

As a result of inadequate training and the absence of published policies, guidelines, or decisions, representatives reported that review panel decisions are not consistent and predictable, but instead vary depending on the composition of the review panel. Some review panels rely on facts for which there is insufficient or unreliable evidence, or simply no evidence at all. There are several deficiencies in the adequacy of reasons for review panel decisions, including unbalanced references to the parties' evidence and arguments, failure to adequately weigh and resolve conflicts in relevant evidence, and insufficient legal analysis and interpretation of the law. Many of these issues could be addressed with improved transparency from the Mental Health Review Board in the form of published policies, guidelines, practice directions, or decisions. While it is critical to protect the privacy interests of *Mental Health Act* detainees and their personal support networks, publication of anonymized review panel decisions could facilitate training and promote transparency and consistency in decision making while safeguarding privacy.

The practice of the Mental Health Review Board Chair in reviewing draft written reasons of review panel members is inconsistent and problematic. The Chair reviews the draft reasons of physician panel members and community panel members before publication, but does not apply the same standard to lawyer panel members. The Chair also reviews all draft reasons for discontinuation of detention, but does not review the draft reasons for continuing detention. This asymmetrical practice appears to establish an expectation that the panel members will decide to continue detention and that discontinuing detention is a departure from that expectation that must be more carefully justified. An internal review of the reasons for decisions can be a useful practice to improve the adequacy of review panel reasons. However, any reviews conducted should be a consistent review of all reasons or an evenly distributed sampling of reasons to avoid jeopardizing the independence of the decisions of tribunal members.

The [Mental Health Review Board](#) should take steps to improve the transparency and consistency of review panel decisions, which as a minimum, should include:

- An improved initial training process and ongoing professional development of review panel members;
- Development of policies or guidelines in consultation with stakeholders to address consistent interpretation of the legal criteria for detention in the *Mental Health Act*;
- Development of a consistent and transparent policy regarding the internal process for reviewing the draft reasons of review panel members; and
- Publication of anonymized review panel decisions.

## SUMMARY OF RECOMMENDATIONS

### REVIEW PANEL DECISIONS

For the Mental Health  
Review Board:

- **Improve the initial training process and ongoing professional development of review panel members.**
- **Address consistent interpretation of the legal criteria for detention.**
- **Develop a consistent and transparent policy regarding the internal process for reviewing the draft reasons of review panel members.**
- **Publish anonymized review panel decisions.**

## ISSUES WITH STATE'S CASE FOR DETENTION BEING PRESENTED BY TREATING PSYCHIATRIST

In legal proceedings individuals play different roles: lawyers are responsible for advancing their client's case, fact witnesses testify about things they have seen and heard, expert witnesses provide opinions through reports and testimony, and decision makers are responsible for adjudication. In review panels, most parties have one clear role: the detainee's role as a party to the proceeding is to present evidence in the form of testimony, the detainee's legal representative's role is to advocate for detention to be discontinued, and the review panel member's role is to make the detention decision. The detaining facility's case presenter however, plays multiple different roles. The case presenter is the representative of the state who is responsible for advocating for detention to be continued and cross-examining the detainee to undermine his case. The case presenter is also typically the detainee's treating psychiatrist, which means she provides factual testimony about the detainee's condition. In addition, the case presenter typically acts as an expert witness by providing opinions based on her medical expertise. This multi-layered role creates challenges for the case presenter and the maintenance of procedurally fair hearings.

Tasking treating psychiatrists with advancing the state's case for detention and providing evidence is an extremely unusual arrangement in legal proceedings. In legal proceedings the state is usually represented by a lawyer or another type of representative who presents the state's position, advances legal arguments, and calls witnesses to provide evidence. An obvious example is a criminal proceeding in which a lawyer known as Crown counsel presents the state's case for conviction. In administrative tribunal settings, the state may be represented by someone who is not a lawyer, but is still responsible for advancing the state's position. For example, in reviewing the liberty restrictions of an individual found not criminally responsible by reason of mental disorder at the BC Criminal Code Review Board, the Attorney General is represented by a lawyer who is responsible for taking a position to ensure public safety, while the detaining facility is generally represented by an individual who may or may not be a lawyer who is responsible for advancing the facility's position and calling treating psychiatrists to provide evidence about the accused as witnesses. At the Immigration and Refugee Board a number of public servants who may or may not be lawyers are designated to represent the Minister of Immigration, Refugees and Citizenship in detention proceedings.

## REPRESENTATIVES REPORTED

Representatives raised many concerns with the current structure of review panel hearings in which the case presenter occupies multiple roles by advancing the state's case for detention, providing factual evidence as the detainee's treating psychiatrist, and acting as an expert witness. First, representatives identified that the unbalanced access to expert evidence between the two parties jeopardized the fairness of review panel proceedings. As discussed, the Mental Health Review Board funds the detaining facility to prepare expert evidence and participate in the hearing, but it will not provide any funding to detainees to participate in a review panel. Detainees rarely have the resources to retain their own medical experts and as a result only one party to the proceeding has access to expert evidence.

Representatives reported that there are many circumstances in which it would be helpful for detainees to have access to a medical expert in presenting their case. For instance, an issue that must be adjudicated at hearings is whether the detainee has a disorder of the mind that requires safe and effective psychiatric treatment and seriously impairs his ability to react appropriately to his environment or to associate with

## IN THE WORDS OF THE LEGAL REPRESENTATIVES:

*“It’s a basic principle that both sides should be stacked fairly.”*

*“From a legal perspective, it creates a weird dynamic to go up against a medical expert when you have no medical expertise... It seems like there’s a different dynamic between me and the panel and the psychiatrist and the panel.”*

others. It is open to detainees to argue that they do not meet the detention criteria because their mental health problems do not rise to the level of serious impairment or that their condition does not require psychiatric treatment. For example, one representative wanted to obtain expert medical evidence that an individual with an acquired brain injury who had been detained in a highly restrictive setting for many years without any improvements to his symptoms did not require psychiatric treatment. However, representatives reported that it is incredibly hard for detainees to advance legitimate lines of argument without access to expert medical evidence.

Lawyers who practice in other areas of law pointed out that in no other legal proceeding would they represent a client in a hearing who did not have any expert evidence when the opposing party was relying on expert evidence. The opposing party in a review panel proceeding not only has a medical expert, but the report containing the expert evidence is usually not disclosed until the hearing begins, which means the detainee and their legal representative have no opportunity to prepare to respond to the evidence. As a result, representatives reported a troubling power imbalance between the parties in review panels. When the individual representing the state in presenting the case for detention is a psychiatrist, the review panel views that party with a great deal of deference.

*“It’s a basic principle that both sides should be stacked fairly.”*

*“[The treating psychiatrist] holds a profound amount of power.”*

*“From a legal perspective, it creates a weird dynamic to go up against a medical expert when you have no medical expertise... It seems like there’s a different dynamic between me and the panel and the psychiatrist and the panel.”*

*“It gives the case for detention a huge leg up and it’s usually loaded in their favour.”*

Second, representatives reported that one of the issues inherent in having a treating psychiatrist present the case for detention is that the psychiatrist is not impartial. In legal proceedings expert witnesses are generally required to conform to a duty of impartiality. For instance, the BC Supreme Court Civil Rules state that in giving an opinion, an expert “has a duty to assist the court and is not to be an advocate for any party.”<sup>44</sup> By advancing the state’s case for detention, the psychiatrist is by definition advocating for a party before the review panel and their expert evidence is not impartial. As a result, their evidence may be filtered through a lens of supporting a particular position: continued detention of the patient. In the words of one representative, “doctors are not impartial in presenting the case for detention — they are the client’s doctor and have different obligations and a different perspective than an administrative representative of the state.”

<sup>44</sup> B.C. Reg. 168/2009, r. 11-2(1).

In addition, representatives pointed to less tangible consequences to the impartiality of proceedings when treating psychiatrists advance the case for detention as a party to the review panel. It is the treating psychiatrist's decision to continue detention that is under review at hearings. Representatives reported that many case presenters did not seem to have adequate training or resources to understand the function of review panels and their role in the process. Representatives observed that some psychiatrists approach review panels with an open mind by acknowledging the importance of checks and balances in any system of detention and treating the panel as an opportunity for their patient to express their points of view and be heard. However, representatives reported that it is much more common for psychiatrists to approach the panel as an unnecessary intervention, a waste of their time, or a challenge to their authority and clinical judgment. Representatives have observed that when a review panel orders detention be discontinued some psychiatrists or other members of the treatment team view this as a loss and react negatively, for example, by refusing to continue providing treatment to the patient on a voluntary basis. Some representatives expressed the view that the level of attachment or defensiveness psychiatrists exhibit may be mitigated if they are not responsible for advocating for detention at hearings.

Legal representatives also reported that it can be challenging to vigorously advocate for their clients when there is no distinction between the state's case for detention and the treating psychiatrist. For instance, some representatives reported feeling reluctant in certain situations to make pointed arguments that detention was inappropriate because the individual who was responsible for continuing detention was the same individual presenting the state's case. Representatives observed that it sometimes appeared that panel members were reluctant to probe into the problems involved in detention because this necessarily involved questioning the individual psychiatrist responsible for the detention who was present at the hearing. Some representatives expressed the perspective that everyone involved in review panels might be more willing to critically examine the case for detention if it was distinguished from the individual treating psychiatrist.

Third, several representatives observed that having a treating psychiatrist present the case for detention may have detrimental consequences for the therapeutic relationship between the detainee and their treating psychiatrist. The majority of review panel hearings result in continued detention, which means that the detainee and their treating psychiatrist are expected to return to the ward after the hearing and continue a therapeutic relationship. Several representatives pointed out that detainees and their treating psychiatrists are advocating for adversarial positions at review panels. Detainees watch their treating psychiatrist arguing for their continued detention to the review panel and psychiatrists can cross-examine detainees to undermine their evidence. Unsurprisingly, this can generate negative feelings and damage the relationship between the psychiatrist and the detainee. Several representatives expressed the view that if another individual was responsible for presenting the state's case for detention and the psychiatrist was only present to provide evidence it could help preserve the therapeutic relationship.

Fourth, some representatives observed that psychiatrists do not appear to have adequate training or resources to fulfill the responsibilities of conducting pre-hearing disclosure, and organizing and presenting the state's case for detention. Representatives reported that many case presenters do not understand their legal obligations to disclose the state's evidence for detention or their role in the hearing. For detainees on prolonged extended leave periods, the treating psychiatrist may go several months without seeing the detainee, which means that they do not always have a thorough understanding of the detainee's current condition. Representatives who had experiences with the rare review panel in which a case manager with a mental health team had presented the case for detention and the psychiatrist only came in to provide testimony reported that it improved the efficacy of the hearing. First, the case manager ensured that the

detainee received pre-hearing disclosure of medical records, second, the case manager often knew more details about the detainee's day to day life, and finally, the psychiatrist appeared to be less personally invested in the outcome of the hearing.

## CONCLUSION AND RECOMMENDATIONS

Tasking a detainee's treating psychiatrist with presenting the state's case for detention has a number of negative implications that jeopardize the fairness of the hearing. It creates unbalanced access to expert medical evidence between the detaining facility and the detainee. In advancing the state's case for detention, the treating psychiatrist is advocating for a party before the review panel and, by definition, cannot provide impartial expert evidence. The partial role the treating psychiatrist occupies may also make it more challenge for all involved in review panels to step back and objectively examine the appropriateness of ongoing detention. Treating psychiatrists advocating for detention and potentially cross-examining the detainee can have detrimental consequences for their therapeutic relationship with the detainee. Finally, treating psychiatrists do not appear to have adequate training or resources to fulfill the responsibilities of conducting pre-hearing disclosure, and organizing and presenting the state's case for detention.

Better training for case presenters would go some way to addressing a few of these issues and the **Ministries of Health and Mental Health and Addictions should work in conjunction with the health authorities** to create standardized provincial policies and training for any health care provider responsible for presenting the state's case for detention at review panels.

However, given the significant procedural fairness deficiencies in review panel hearings, it is time to consider a structural change. The **BC Government** should review the current structure and consider creating a new role for a lawyer or another individual with adequate legal training to act on behalf of the detaining facility in presenting the case for detention. This individual could be responsible for conducting the facility's pre-hearing disclosure, scheduling an appropriate physical location in the facility for the hearing to take place, addressing pre-hearing issues, presenting the argument for detention at the hearing, calling the detainee's treating psychiatrist or other health care providers to give evidence, and cross-examining the detainee. These are all areas currently subject to many fairness problems identified by representatives throughout this report. Appointing a state representative with training and responsibility to conduct the detaining facility's legal case, who is not also simultaneously responsible for the detainee's medical treatment, could create substantial improvements to the review panel process.

### SUMMARY OF RECOMMENDATIONS

#### PRESENTATION OF CASE FOR DETENTION

For the BC Government:

- Review the current structure and consider creating a new role for a lawyer or another individual with adequate legal training to present the case for detention.

For the Ministries of Health and Mental Health and Addictions in conjunction with the health authorities:

- Create standardized provincial policies and training for health care providers responsible for presenting the case for detention at review panels.





# 7 | Oversight and Accountability

## OVERVIEW

Detention is an extraordinary and intrusive exercise of state power. As discussed throughout this report, detaining facilities in BC can control virtually every aspect of a *Mental Health Act* detainee's life, including placement in restraints and seclusion and forced administration of psychiatric treatment. In a free and democratic society, such extraordinary power must be subject to careful oversight and accountability mechanisms. Several different actors are responsible for overseeing the administrative system for mental health detention in BC.

The mental health detention system is administered on the ground largely by health care providers: physicians who make detention decisions, nurses who sign Form 5s to authorize forced psychiatric treatment, and social workers who provide legal rights information. Health authorities establish training and policy and are responsible for the actions of health care providers. The health authorities are in turn accountable to government ministries, such as the Ministry of Health. The BC Government is ultimately responsible for its legislation and regulation, including the *Mental Health Act* and the *Mental Health Regulation*, through the legislature and the relevant ministries. Finally, the Mental Health Review Board and the courts are responsible for adjudicating challenges to *Mental Health Act* detention.

While movements for rights are often advanced by the advocacy of individuals who have had their rights deprived, it is challenging for individuals in mental health detention to engage in sustained self-advocacy or initiate complaints. As a result, the exercise of power over detainees should be subject to conscientious safeguards and monitoring even in the absence of the threat of individual complaints. As the Ombudsperson pointed out in *Listening*, “[p]eople who are periodically disengaged because of a psychiatric disability or treatment side-effects are entitled to fairness and justice even if they cannot demand them. One way to guard against unfairness is to put mechanisms for accountability in place.”<sup>1</sup>

This section will explore five issues of oversight and accountability. First, the section will discuss the narrow jurisdiction of the Mental Health Review Board, which leaves detainees with no effective recourse to challenge many decisions that affect them. Second, the section will consider the role that courts play in supervising *Mental Health Act* detention issues and the barriers that detainees face in accessing the courts.

<sup>1</sup> British Columbia, Office of the Ombudsperson, *Listening: A Review of Riverview Hospital*, Public Report No. 33 (May 1994), online: <<https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2033%20Listening%20A%20review%20of%20Riverview%20Hospital.pdf>> [*Listening*] at 2-4.

**The jurisdiction of the Mental Health Review Board is limited to one legal issue: determining whether detention should continue. Detainees have no way to seek review of any other issues that impact them, such as facility placement, forced psychiatric treatment, or the use of seclusion and restraints.**

Third, the section will discuss the lack of transparency in the form of annual reports or other accountability and governance documents from the Mental Health Review Board. Fourth, the section will consider the issue of inadequate transparency and accountability from the Ministry of Health and the health authorities in supervising *Mental Health Act* detention issues. Finally, the section will conclude with a discussion on the absence of systemic reviews and effective complaint mechanisms for detainees.

## INADEQUATE JURISDICTION OF THE MENTAL HEALTH REVIEW BOARD

The jurisdiction of the Mental Health Review Board is limited to one legal issue: determining whether detention should continue because the legal criteria for detention continue to describe the condition of the patient. Detainees have no way to seek review from the Mental Health Review Board of any other issues that impact them, such as facility placement, conditions of leave from facilities, forced psychiatric treatment, the use of seclusion and restraints, or the deprivation of privileges. As discussed throughout this report, *Mental Health Act* detention is a significant infringement of many different *Charter* rights, such as the s. 7 right to life, liberty, and security of the person. The state may only deprive individuals of their s. 7 rights in accordance with the principles of fundamental justice, which includes the right to a fair process to ask an independent decision maker to review the state's actions.

As discussed in section 1 | [Detention Decisions](#), the BC *Mental Health Act* permits indefinite detention on the basis of continually renewed 6 month certificates. As a result, there are some individuals in BC who have been detained for many years on cycling 6 month certificates. In *P.S. v. Ontario*, the Ontario Court of Appeal unanimously ruled that it was a violation of the *Charter* to allow indefinite detention without sufficient oversight to ensure a patient's liberty is not unnecessarily restricted. Like the BC statute, the Ontario *Mental Health Act* had a scheme of increasingly prolonged certification periods with no limit to prevent indefinite detention on cycling certificates. Although the relevant tribunal, the Consent and Capacity Board, had significantly broader jurisdiction than the BC Mental Health Review Board, it lacked the power to order that PS be transferred from a maximum security facility to a less restrictive setting. The Court found that:

*...in the non-punitive detention context, s. 7 requires the body reviewing detention to have the procedures and powers necessary to render a decision that is minimally restrictive on liberty in light of the circumstances necessitating the detention. ... By failing to confer upon the CCB the*

*necessary authority, the MHA fails to ensure, as required by Winko and Penetanguishene, that “at every step of the process consideration of the liberty interest of the [detained individual is] built into the statutory framework.” Specifically, the [Consent and Capacity Board] lacks the jurisdiction to supervise the security level, privileges, therapy and treatment of long-term detainees and to craft orders that would ensure an appropriate balance between public protection and the protection of detainees’ liberty interests.<sup>2</sup>*

## REPRESENTATIVES REPORTED

Legal representatives expressed significant concern over the lack of administrative oversight of rights deprivations for *Mental Health Act* detainees, one representative describing the jurisdiction of the Mental Health Review Board as “woefully inadequate”. Several reported that their clients often expressed disappointment and frustration on learning how limited the jurisdiction of a review panel is. Representatives pointed out that many detainees request a review panel not because they want to be discharged, but because they want to object to some other enforced condition of their lives, such as being placed in seclusion, being denied day passes to the community, or being forcibly administered a particular psychiatric treatment.

Although legal representatives expressed a variety of perspectives on which areas there should be a mechanism of review for and the appropriate forum for that review, they were unanimous in expressing that there was inadequate administrative oversight to ensure rights deprivations of detainees were procedurally and substantively fair. Representatives were generally of the view that an administrative body overseeing *Mental Health Act* detentions should be able to at least consider the detainee’s liberty and security of the person interests and make recommendations or orders regarding the level of intrusions on these rights.

Some representatives stated that while some administrative body should have jurisdiction to oversee rights deprivations of detainees, the Mental Health Review Board was not the best forum given the insufficient training level of members and the lack of clear tribunal procedures, policies, and guidelines. However, those who represent clients found not criminally responsible by reason of mental disorder at hearings of the BC Criminal Code Review Board pointed out that this tribunal had jurisdiction to consider incursions on an accused’s liberty more broadly and the make-up of panel member expertise and background was almost identical to that of the Mental Health Review Board. While legal representatives identified several areas of rights deprivations for detainees over which there should be some administrative oversight or mechanism of review, the three most common areas raised were extended leave; seclusion, restraints, or privileges; and treatment.

Detainees currently have no way to seek review of any decision related to extended leave. Treating physicians have complete discretion to deny detainees placement in the community on extended leave for any reason. In addition, treating physicians have complete discretion to impose any condition of leave that detainees must legally comply with. While conditions typically require a detainee to adhere to treatment recommendations and check in with the treatment team periodically, other extended leave conditions can seriously infringe on a detainee’s mobility rights. For example, extended leave conditions can mandate that a detainee live in a specific place or with a specific person. If the location they are legally obligated to live in is not safe, this puts the detainee in the impossible situation of choosing between complying with the conditions of extended leave and trying to find a safe place to live. Finally, treating physicians

<sup>2</sup> *P.S. v. Ontario*, 2014 ONCA 900 at paras. 92, 115.

have complete discretion to issue a warrant for police to apprehend detainees and recall them to facilities when they believe detainees have breached their conditions of leave. The recall could be issued on the basis of an interaction between the detainee and the treating physician, but it could also be on the basis of something as flimsy as a third party phoning a physician with collateral information about the detainee.

Representatives were also concerned that detainees had no mechanism to seek review of the use of seclusion (solitary confinement in a small, locked room), restraints, or restrictions on privileges. As discussed in detail in section 2 | [Restraints and Seclusion](#), unlike other detained populations, *Mental Health Act* detainees can be placed in seclusion or tied in 4-point or 5-point restraints for indefinite lengths of time without review. Treating physicians also have complete discretion to grant or deny detainees any privilege, such as access to clothing, passes to the community, or the right to use a phone or access the internet. A few representatives reported that at times it seemed as if the panel members were concerned about the use of restraints or other restrictions on a detainee's freedom, but they had no authority to comment on the issue. For example, one representative recounted an example of a physician panel member expressing significant concern about a psychiatrist's use of prolonged seclusion as a treatment method for a detainee.

Finally, many representatives reported that the absence of oversight of forced psychiatric treatment was an alarming vacuum. As discussed in section 4 | [Psychiatric Treatment](#), a treating physician can unilaterally decide to forcibly administer any psychiatric treatment to *Mental Health Act* detainees without assessing their capability to make treatment decisions or seeking consent from the individual or anyone else. Although some representatives have tried to present arguments to review panels that a detainee did not meet detention criteria because she was not receiving safe and effective psychiatric treatment, without jurisdiction to review psychiatric treatment, many review panel members have refused to engage with legal questions of treatment efficacy.

*"This is something I've really brought up so often [at review panels] to very little use — the efficacy of these medications... the diagnosis will be made on specific delusions or... behaviour that is thought to be based on some delusions and then there's a history of sort of medication on and off... and there's no kind of correlation. You know, they have delusions when they're on their meds, they have delusions when they're off their meds, it doesn't seem to have any effect, you know, when you do a timeline... and I say 'well, do you think the medications are working?' and the doctor says, 'well, I don't know'. And I say ... 'your whole reason for ongoing detention really comes down to this incident, but the patient was on medication here, you know, what's the efficacy rate?' — 'well, it's about 50%' — 'well, do you think it's working?' — 'well, I don't know'... Well why can't he be taken off medication? ... He hates it, it has side effects and there's no evidence that it's working."*

The only form of oversight on unilateral forced psychiatric treatment in the *Mental Health Act* is the option to request a second opinion pursuant to s. 31(2). For the reasons discussed in section 4 | [Psychiatric Treatment](#), representatives reported that second opinions are not an independent and effective means of oversight for the exercise of such a significant power. Several representatives observed that detainees are usually willing to engage with some kind of treatment, but have concerns about particular treatments being forced on them, such as Electroconvulsive Therapy or a specific psychotropic pharmaceutical agent that is causing significant side effects. Representatives were of the opinion that a tribunal procedure could be an effective process to create dialogue and oversight on treatment issues.

*"The review panel has a lot of value in creating a conversation between a patient and doctor that seems to have not happened before the panel. Partly because the doctors are overworked, but also partially because mental health patients feel empowered by having counsel because it's someone that they know has no vested interest in anything else that's going on other than getting their thoughts heard."*

## IN THE WORDS OF THE LEGAL REPRESENTATIVES:

“The review panel has a lot of value in creating a conversation between a patient and doctor that seems to have not happened before the panel. Partly because the doctors are overworked, but also partially because mental health patients feel empowered by having counsel because it’s someone that they know has no vested interest in anything else that’s going on other than getting their thoughts heard.”

Representatives reported several other issues that impact detainees’ rights for which there is no administrative oversight outside these three themes. For instance, several representatives pointed out that the Mental Health Review Board lacked jurisdiction to make findings or orders related to the breach of the most basic rights detainees have pursuant to the *Mental Health Act*. This could be something as straightforward as the deprivation of one of the rights articulated in Form 13, such as the right to contact a lawyer or the right to receive the reasons for detention in the Form 4 or Form 6.

However, representatives reported that they had sometimes uncovered the alarming fact at review panels that an individual’s detention certificates were never properly completed or had lapsed and the individual was illegally detained. Although historically the review panel used to automatically order a discharge in such circumstances, an addition to the *Mental Health Act* in s. 25(2.2) states that a review panel must conduct a hearing despite any defect or apparent defect in the authority for the initial or continued detention of a patient. While s. 25(2.2) may be intended to act as a safety mechanism to ensure detainees get a hearing without further delay, some representatives were of the view that fettering the jurisdiction of the review panel by mandating it proceeds in the face of an illegal detention trivializes the significant authority involved in detention.

Detainees are entitled to seek financial compensation for the tort of wrongful imprisonment and battery when they have been detained and forcibly treated without legal authority. However, it can be overwhelming for individuals who are still in detention or have only recently regained their freedom to initiate a law suit against the detaining facility. There are many barriers to detainees locating and being able to afford legal advice and representation to pursue such a claim, as discussed in more detail in the following section. As a result, representatives reported that they had not heard of a detainee pursuing compensation for wrongful imprisonment or battery after advising them that they had a claim, which means there are no consequences to detaining facilities that have illegally detained someone.

One representative suggested that a solution to this lies in granting the Mental Health Review Board jurisdiction to levy a statutorily defined minimum amount of compensation to detainees when the *Mental Health Act* is violated. The authority to order that a party pay another party for violating a statute exists with other administrative actors in BC. For example, in a Residential Tenancy Branch proceeding, a landlord must pay a tenant double the amount of the damage deposit for failure to return a damage deposit within the statutory timeline.<sup>3</sup> Similarly, a landlord must pay a tenant double the amount of the monthly rent as compensation for evicting a tenant for landlord’s use of property and failing to take steps to use the property for the stated purpose within a reasonable period.<sup>4</sup> The *Mental Health Act* could establish a mechanism for the Mental Health Review Board to order detaining facilities to compensate detainees a

<sup>3</sup> *Residential Tenancy Act*, S.B.C. 2002, c. 78, s. 38.

<sup>4</sup> *Ibid*, s. 51.

statutorily defined minimum amount of compensation for being detained without legal authority, such as \$2000 per day of wrongful detention. This would not prevent a detainee from pursuing a claim of wrongful imprisonment and battery in another legal proceeding to prove that they suffered more damages than this, but it would provide an accessible mechanism for detainees to receive compensation for wrongful detention in a review panel proceeding that was already underway.

## CONCLUSION AND RECOMMENDATIONS

Administrative tribunals are intended to provide a fast, accessible, and cost-effective legal alternative to courts. While this report has identified many deficiencies with the Mental Health Review Board processes, including insufficient member training, procedural fairness issues, and inconsistent decision-making, it is effectively the only independent legal mechanism that *Mental Health Act* detainees have had access to for several years, an issue that will be discussed further in the following section. However, the jurisdiction of the Mental Health Review Board is inadequate to provide the administrative oversight required by the *Charter* of such significant rights deprivations. As a result, detainees have no accessible legal mechanism to challenge fundamental issues like extended leave decisions and conditions, the use of restraints and seclusion, or forced psychiatric treatment.

The **BC Government** should review and amend the *Mental Health Act* and related statutes to create an independent administrative body that provides effective oversight. Amendments must, as a minimum, provide administrative oversight of areas of significant rights deprivations for detainees, such as:

- 1) Exercises of discretion related to facility placement, placement on extended leave, conditions of extended leave, and recall of a detainee from extended leave;
- 2) Exercises of discretion related to the use of seclusion, restraints, and privileges; and
- 3) The administration of forced psychiatric treatment.

A statutorily defined levy against facilities that detain individuals without legal authority presents several advantages. It would go some way to compensating a detainee for wrongful detention without laying the burden on the detainee to initiate a new legal claim. It would also create a consequence to detaining facilities for wrongfully detaining individuals and therefore create an incentive to ensure that individuals held in facilities were lawfully detained. The **BC Government** should consider an amendment to the *Mental Health Act* to grant an independent administrative body jurisdiction to order that detaining facilities pay a statutorily defined minimum amount of compensation to wrongfully detained individuals.

## SUMMARY OF RECOMMENDATIONS

### JURISDICTION OF THE MENTAL HEALTH REVIEW BOARD

For the BC Government:

- Review and amend the *Mental Health Act* and related statutes to create an independent administrative body that provides effective oversight of the conditions of detention.
- Review the *Mental Health Act* to consider an amendment to grant an independent administrative body jurisdiction to order that detaining facilities pay a minimum amount of compensation to wrongfully detained individuals.



## INADEQUATE COURT SUPERVISION OF MENTAL HEALTH REVIEW BOARD AND CONDITIONS OF DETENTION

Although the Mental Health Review Board is the primary legal forum that adjudicates *Mental Health Act* detention issues, the BC Supreme Court may also review detention. First, any detainee, or a person on behalf of the detainee, can make a statutory application to Court pursuant to s. 33 of the *Mental Health Act* for a number of orders, including a discharge, on the basis that there is not sufficient reason or legal authority for a certificate. Second, every detainee has the right pursuant to s. 10(c) of the *Charter* to make a *habeas corpus* application to determine whether the detention is valid. Finally, as in any administrative system, the Court maintains a supervisory authority over administrative decision makers through judicial review of a review panel's decision. If a review panel process is procedurally unfair or it made an error in its decision, the Court can set aside a review panel's decision on judicial review.

It is clear that although these court mechanisms exist as theoretical options, detainees are currently not able to access the courts. Despite the thousands of people involuntarily detained every year in BC, there have only been two published judgments resulting from detainees challenging their detention since the last significant amendments were made to the *Mental Health Act* in 1998.<sup>5</sup> In *N.T. v. Facility*,<sup>6</sup> an unrepresented detainee was denied release in a s. 33 statutory *Mental Health Act* application. The second case was an extremely unusual situation involving an individual detained in a correctional facility, not a designated mental health facility. In *R. v. Anderson*,<sup>7</sup> an accused person had been certified under the *Mental Health Act*, but was being detained at Vancouver Island Regional Correctional Centre. His criminal defence lawyer made a number of applications on his behalf relating to criminal procedures. His *habeas corpus* application was dismissed because he was not actually applying for release, but to be transferred to a designated mental health facility.

The concern that detainees are not able to effectively access the courts is not a new one. In the 1994 *Listening* report, the Ombudsperson expressed concern about how few statutory *Mental Health Act* applications were being made and criticized the inadequate funding provided to detainees by the Legal Services Society to exercise their rights. The report concluded that expanding the scope of legal representation may make it easier for detainees to bring court applications, "which currently is a statutory right without effective means to access it."<sup>8</sup>

Extending the case law search back even further than the 1998 revisions reveals only a handful of published decisions from detainees challenging their detention in the last several decades among the tens of thousands of detentions:

- *Dearing v. Riverview Hospital*, [1975] B.C.J. No. 909 (S.C.) — a *habeas corpus* application in which the detention certificates had been improperly completed when the petitioner was originally admitted. The application was denied on the grounds that new medical certificates had been subsequently filled out correctly.

5 We used both Quicklaw and WestlawNext to search for decisions citing the application for discharge provision (now s. 33 of the BC *Mental Health Act*, but previously s. 27 from 1979 to 1987, s. 75 from 1987 to 1990, s. 27 again from 1990 until 1996, and s. 33 from 1996 until present). We then searched both databases for cases citing the BC *Mental Health Act* and containing the phrase "*habeas corpus*". Finally, we searched for cases citing the BC *Mental Health Act* and containing the phrase "judicial review".

6 2012 BCSC 1162.

7 2014 BCSC 395.

8 *Listening* at 9-22.

- *Hilton v. Duffy*, [1980] B.C.J. No. 919 (S.C.)—a *habeas corpus* application in which the petitioner successfully applied to be transferred from a hospital to a correctional centre because he did not want to have treatment forced on him.
- *Robinson v. Hislop*, [1980] B.C.J. No. 1878 (S.C.)—a statutory *Mental Health Act* application in which the petitioner was denied release.
- *Scherba v. Riverview Hospital*, [1981] B.C.J. No. 915 (S.C.)—a statutory *Mental Health Act* application in which the petitioner was denied release.
- *Hoskins v. Hislop*, [1981] B.C.J. No. 2127 (S.C.)—a statutory *Mental Health Act* application in which the petitioner was denied release.
- *Robinson v. Kirby*, [1984] B.C.J. No. 1127 (S.C.)—a statutory *Mental Health Act* application in which the same petitioner in *Robinson v. Hislop* was denied release again four years later.
- *Garnett v. Duffy*, [1987] B.C.J. No. 244 (S.C.)—McEachern CJBC ordered the discharge of a *Mental Health Act* detainee. It is possible that the discharge resulted from a statutory *Mental Health Act* application, but it is not completely clear from the oral transcript what the basis was for the order.
- *Greggor v. Riverview Hospital*, [1992] B.C.J. No. 694 (S.C.)—a statutory *Mental Health Act* application and a *habeas corpus* application in which the petitioner was denied release.
- *McCorkell v. Riverview Hospital*, [1993] B.C.J. No. 1518 (S.C.)—although this case began as a judicial review of a review panel decision, at the time of the trial, the petitioner was no longer detained so discharge was not contemplated.
- *Winder v. Review Panel under Mental Health Act*, [1993] B.C.J. No. 1565 (S.C.), aff'd [1994] B.C.J. No. 193 (C.A.), leave to appeal to S.C.C. refused [1994] S.C.C.A. No. 146—a judicial review of a review panel decision in which the judge ruled that review panels do not have the jurisdiction to decide whether a certificate was invalid for noncompliance with the *Mental Health Act*.

There are only handful of published decisions from detainees challenging their detention in the last several decades among the tens of thousands of detentions.

## REPRESENTATIVES REPORTED

Representatives reported that there are multiple barriers that prevent *Mental Health Act* detainees from accessing the courts. First, it is possible that detainees do not know about the existence of court applications. As discussed in section 3 | [Access to Information and Legal Advice](#), detainees have no access to independent rights advice on detention. It is the obligation of the director of a detaining facility to provide detainees with rights information on detention and renewal, including information on the right to contact a lawyer, the right to seek a court review of detention pursuant to a s. 33 statutory *Mental Health Act* application, and the right to seek a court review of detention through a *habeas corpus* application. In practice, the director delegates the

There is no legal aid funding for detainees to access independent rights advice on detention, which means the right to contact a lawyer is largely a theoretical one.

provision of rights information to social workers, nurses, physicians and other staff involved in detention. The Legal Services Society provides no funding for detainees to access independent rights advice on detention or renewal, which means the right to contact a lawyer is largely a theoretical one. Several representatives pointed out that if detainees are not accessing the courts through these mechanisms, it is a good indication that detainees are not receiving adequate information and facilitation to exercise their rights.

Second, even if a detainee is adequately informed of their right to access these court applications, representatives reported that finding a lawyer to provide legal advice and representation in these court applications is an extraordinary challenge for detainees. Unlike other legal aid areas, such as immigration law, criminal law, and family law, the Legal Services Society has not established a telephone line or duty counsel for *Mental Health Act* detainees. When detainees are told on detention and renewal that they have the right to contact a lawyer, they are expected to be able to find that lawyer. A detainee on an inpatient ward may not have access to the basic tools necessary to do the research to find a lawyer, including a phone, a phone book, a computer or internet, paper, pens, or day passes to go to lawyers' offices, courts, or legal resource centres in person. Very few lawyers practice in the area of mental health law and even fewer advertise that they do. Although an administrative law lawyer might be able to provide advice and representation to those involved in a system for administrative detention, *Mental Health Act* detainees would not necessarily understand what administrative law is or what lawyers mean when they advertise themselves this way.

Third, assuming a detainee finds a lawyer who is able and willing to provide advice and representation, many detainees do not have the funds available to hire a lawyer. Many individuals with mental health diagnoses are recipients of disability assistance or have experienced interruptions in their employment income from mental health problems and detention. Legal representatives reported that while they were unsure whether the Legal Services Society would grant an application for legal aid to pursue court cases related to *Mental Health Act* detention, there simply was no established practice of making such applications. For instance, one lawyer explained that he once looked into the work involved in applying for legal aid to represent a detainee in a judicial review of a problematic review panel decision and concluded that even if the application for legal aid was successful it would be a significant cost to him to represent the detainee. He pointed out that he already lost income representing detainees at review panels and while he was willing to do low-bono and pro-bono work, it simply was not realistic to expect lawyers to continually lose money in representing detainees.

On the topic of accessing judicial review of review panel decisions specifically, representatives reported that it can be challenging for detainees to meet the 60 day deadline to file a judicial review following the review panel decision given all the barriers to accessing legal information, advice, and representation discussed. Some representatives pointed out that unlike many other administrative bodies, the Mental Health Review Board does not inform detainees of their options to challenge

## IN THE WORDS OF THE LEGAL REPRESENTATIVES:

*“The people that are being held under the *Mental Health Act* are really, they’re the most — and I’ve done a lot of legal aid work and poverty law work — and they are the most powerless of the powerless.”*

a decision when it is delivered to the detainee. One representative reported that when she attempted to assist a detainee in judicially reviewing a review panel decision that contained serious errors, the Mental Health Review Board Chair at the time decided to schedule another review panel for the detainee. While this did promptly address the problem of the unfair hearing for the detainee, it also meant that the court case could not proceed. If cases do not proceed to court it forecloses the potential for advancement in the judicial interpretation and application of mental health law to guide tribunal members.

Finally, representatives reported several other barriers to detainees exercising their right to pursue court applications. Some pointed out that detainees must face the risk of a court cost award against them if they lose the court application. Others observed that while review panel proceedings and decisions were private, court proceedings and decisions are public unless otherwise ordered, which means that detainees face the risk of public exposure of their identity. Some pointed out that it can be challenging for detainees to gather the necessary information to consider whether they have a potentially meritorious argument to advance in a court application given how frequently detainees are denied access to their own records by detaining facilities. Finally, several representatives reported that lengthy wait times to get court dates meant that detainees often had the right to another review panel before a court application could proceed. All of these disadvantages can contribute to a detainee’s decision not to pursue even the strongest case to court. For example, one lawyer reported advising a detainee that she had an excellent case for judicial review of a review panel decision in which a retired physician occupied the community member slot of the panel and spent an inordinate length of time asking medically based questions, however, the client was too fearful of the risks involved in the court application to pursue the case.

*“The people that are being held under the *Mental Health Act* are really, they’re the most — and I’ve done a lot of legal aid work and poverty law work — and they are the most powerless of the powerless.”*

## CONCLUSION AND RECOMMENDATIONS

As discussed in section 3 | [Access to Information and Legal Advice](#), tasking detaining facility staff with providing rights information to detainees is deeply problematic. The near complete absence of court applications from detainees seeking review of detention through any of the available mechanisms is yet another indication that detainees are not getting access to the legal information, advice, and representation that they are entitled to. Given the significant *Charter* interests at stake, the substantial deficiencies in rights advice to detainees must be addressed by creating a framework for independent rights advice. Short of a legislative amendment, many actors could take steps to improve access to legal information, advice, and representation for detainees. The Ministry of Health and health authorities could evaluate the efficacy of rights information provision and create better policies and training for health care providers who are

## SUMMARY OF RECOMMENDATIONS

### COURT SUPERVISION

For the BC Government:

- Review and amend the *Mental Health Act* to create a statutory framework for prompt, independent rights advice.

For the Legal Services Society:

- Provide funding for detainees to access legal advice on detention and detention renewal.
- Provide funding for detainees to obtain legal representation to pursue s. 33 statutory applications, *habeas corpus* applications, and judicial reviews of review panel decisions.

For the Ministries of Health and Mental Health and Addictions in conjunction with the health authorities:

- Create standardized provincial policies and training for health care providers who provide rights information to detainees.

For the Mental Health Review Board:

- Provide information to detainees regarding their options for challenging review panel decisions when delivering written reasons for the decision.

responsible for providing rights information. The Legal Services Society could take several different steps to fund and improve access to legal information, advice, and representation through legal aid initiatives to detainees. The Mental Health Review Board could adopt the practice of other administrative decision makers by providing detainees with information regarding their options for challenging review panel decisions when delivering written reasons for the decision.

The **BC Government** should review and amend the *Mental Health Act* to create a statutory framework for prompt, independent rights advice. Amendments must, as a minimum, address the following:

- 1) A protected role for an independent organization to provide rights advice to detainees as appointed by the Minister;
- 2) Sufficient safeguards to ensure that rights advisors are independent from the detaining facility and health authority;
- 3) A process that requires the director or delegates to immediately notify rights advisors when a detainee is apprehended or detained;
- 4) Timing requirements that addresses a process for promptly informing detainees of their rights on all methods of apprehension and detention; and
- 5) Provision of adequate funding to the independent organization responsible for providing rights advice.

Regardless of legislative reform, the **Legal Services Society** should provide funding for detainees to access legal advice through duty counsel or an independent organization, or at the least, a toll-free telephone line staffed with legal advocates or lawyers. The **Legal Services Society** should also fund legal representation for detainees to pursue statutory applications pursuant to s. 33 of the *Mental Health Act*, *habeas corpus* applications, and judicial reviews of review panel decisions.

Regardless of legislative reform, the **Ministries of Health and Mental Health and Addictions should work in conjunction with the health authorities** to create standardized provincial policies and training for health care providers who are responsible for providing rights information to detainees.

The **Mental Health Review Board** should provide information to detainees regarding their options for challenging review panel decisions when delivering written reasons for the decision.

## INADEQUATE TRANSPARENCY AND ACCOUNTABILITY OF MENTAL HEALTH REVIEW BOARD

Besides its Rules of Practice and Procedures, the Mental Health Review Board does not publish any type of policies, guidelines, practice directions, accountability documents, or annual reports. As the goal for any administrative system is fair and transparent functioning, the complete absence of published information is unusual for a tribunal. The *BC Administrative Tribunals Act* sets out information that tribunals are generally required to report on:

**59.2** At the times, and in the form and manner, prescribed by regulation, the tribunal must submit the following:

- (a) a review of the tribunal's operations during the preceding period;
- (b) performance indicators for the preceding period;
- (c) details on the nature and number of applications and other matters received or commenced by the tribunal during the preceding period;
- (d) details of the time from filing or commencement to decision of the applications and other matters disposed of by the tribunal in the preceding period;
- (e) results of any surveys carried out by or on behalf of the tribunal during the preceding period;
- (f) a forecast of workload for the succeeding period;
- (g) trends or special problems foreseen by the tribunal;
- (h) plans for improving the tribunal's operations in the future;
- (i) other information as prescribed by regulation.

The Mental Health Review Board does not publish any type of policies, guidelines, practice directions, accountability documents, or annual reports.

The Mental Health Review Board has in fact been legally required to produce annual reports containing the information set out in s. 59.2 of the *Administrative Tribunals Act* since December 18, 2015.<sup>9</sup> The Mental Health Review Board has been in breach of this legal obligation every year since that time in failing to produce an annual report. It speaks volumes to the insufficient oversight from the Minister of Health in the administrative system for *Mental Health Act* detentions that no one noticed and informed the Mental Health Review Board of its violation.<sup>10</sup>

Regardless of any legal requirement to do so, it is common for administrative tribunals in BC to publish annual reports. For example, the British Columbia Human Rights Tribunal publishes an annual report that, among other things, provides statistics on the Tribunal's work, summarizes judicial reviews and other legal developments, tracks the rate of legal representation and its impact on the outcome of complaints, and

<sup>9</sup> Bill 18 — 2015, *Administrative Tribunals Statutes Amendment Act*, 4th Sess., 40th Parl., British Columbia, 2015, cl. 29 (assented to 14 May 2015), S.B.C. 2015, c. 10, online: <<https://www.leg.bc.ca/parliamentary-business/legislation-debates-proceedings/40th-parliament/4th-session/bills/third-reading/gov18-3>>.

<sup>10</sup> Interview of Mental Health Review Board Acting Chair [15 February 2017].



discloses operation costs.<sup>11</sup> The Workers' Compensation Appeal Tribunal publishes Quarterly Reports to the Community with ongoing statistics, as well as comprehensive annual reports that include information on operation costs, performance evaluation, annual statistics, judicial reviews and legal developments, and efforts to educate tribunal members to strive for "decision-making that is predictable, consistent, efficient, independent, and impartial."<sup>12</sup> The BC Criminal Code Review Board publishes an annual report with information on the operating environment, statistics, budget and expenditure overview, and a 3-year work plan with performance objectives.<sup>13</sup>

Comparable civil mental health tribunals in other Canadian jurisdictions also publish annual reports and various other accountability and governance documents. For instance, the Ontario Consent and Capacity Board publishes an annual report that details performance measures, accomplishments, tribunal member training, caseload management, statistics, finances, and legal developments.<sup>14</sup> The Consent and Capacity Board also publishes multiple accountability documents, including a Consultation Policy, a Services Standard Policy, an Ethics Plan, and Performance Evaluation Program and Standards.<sup>15</sup> The Nova Scotia Review Board publishes an annual report that provides an overview of the board's applications and hearings broken down in a regional comparison, presents statistics and trends of the board's operation, and outlines issues of concern and recommendations to the minister.<sup>16</sup> Although these two tribunals have a broader mandate than the BC Mental Health Review Board, mental health tribunals with much smaller jurisdictions and file loads still publish annual reports. For example, the Newfoundland and Labrador Mental Health Care and Treatment Review Board held only 41 hearings to review involuntary certificates in the 2015-16 fiscal year, but published an annual report that provides a comprehensive overview of the tribunal's activities, statistics, and finances as well as objectives and indicators identified in an activity plan.<sup>17</sup>

It is also common for administrative bodies to produce policies or guidelines that assist parties and decision makers in interpreting and applying the enabling statute in a fair and consistent way. For example, the Residential Tenancy Branch has produced Policy Guidelines to promote understanding of the intent of the legislation and enable parties to present their case to arbitrators in an effective way. There are currently 47 distinct Policy Guidelines, clarifying wide-ranging topics from arbitrators' powers to clarify or correct decisions to interpreting pet clauses in tenancy agreements.<sup>18</sup> Similarly, WorkSafeBC has produced multiple Practice Directives following extensive consultation efforts, which "serve to support quality

11 See for instance, BC Human Rights Tribunal, "Annual Report 2015-2016", (Victoria: BC Human Rights Tribunal, 9 June 2016), online: <[http://www.bchrt.bc.ca/shareddocs/annual\\_reports/2015-2016.pdf](http://www.bchrt.bc.ca/shareddocs/annual_reports/2015-2016.pdf)>.

12 See for instance, Workers Compensation Appeal Tribunal, "Workers' Compensation Appeal Tribunal (WCAT) Quarterly Report To The Community For The Period Ended March 31, 2017", (Victoria: Workers' Compensation Appeal Tribunal) at 13, online: <[http://www.wcat.bc.ca/research/WCAT\\_publications/WCAT\\_reports/quarterly\\_reports/17\\_mar\\_qtr.pdf](http://www.wcat.bc.ca/research/WCAT_publications/WCAT_reports/quarterly_reports/17_mar_qtr.pdf)>.

13 See for instance, British Columbia Review Board, "Annual Report Fiscal Year: April 2013 — March 2014" (Victoria: British Columbia Review Board), online: <<http://www.bcrb.bc.ca/Annual%20report%20complete%202014.pdf>> [British Columbia Review Board *Annual Report 2013-2014*]; British Columbia Review Board, "BC Review Board 3-Year Work Plan/ Performance Objectives: April 2012 — March 2015", (Victoria: British Columbia Review Board), online: <<http://www.bcrb.bc.ca/Workplan%202012%20V3%20April%202014%20-%20March%202015.pdf>>.

14 See for instance, Consent and Capacity Board, "Annual Report 2015-2016 (Fiscal Period — April 1, 2015 to March 31, 2016)", (Toronto: Consent and Capacity Board), online: <<http://www.ccboard.on.ca/english/publications/documents/annualreport20152016.pdf>>.

15 Consent and Capacity Board, "Accountability Documents", online: <<http://www.ccboard.on.ca/scripts/english/accountability/index.asp>>.

16 See for instance, Nova Scotia, Review Board, "Involuntary Psychiatric Treatment Act (IPTA) Annual Report 2015-2016", (Halifax: Review Board), online: <<https://novascotia.ca/dhw/publications/Involuntary-Psychiatric-Treatment-Act-IPTA-Annual-Report-2015-2016.pdf>>.

17 See for instance, Newfoundland and Labrador, the Mental Health Care and Treatment Review Board, "Annual Activity Report 2015-2016", (St. John's: The Mental Health Care and Treatment Review Board), online: <[http://www.health.gov.nl.ca/health/publications/pdf/Mental\\_Health\\_Care\\_Treatment\\_Review\\_Board\\_AR\\_2015\\_16.pdf](http://www.health.gov.nl.ca/health/publications/pdf/Mental_Health_Care_Treatment_Review_Board_AR_2015_16.pdf)>.

18 British Columbia, Residential Tenancy Branch, "Tenancy Policy Guidelines Listed by Number" (25 October 2017), online: <<https://www2.gov.bc.ca/gov/content/housing-tenancy/residential-tenancies/calculators-and-resources/policy-guidelines/policy-guidelines-listed-by-number>>.

## IN THE WORDS OF THE LEGAL REPRESENTATIVES:

Representatives overwhelmingly reported that the lack of information published by the Mental Health Review Board made the tribunal's functions and internal operating decisions seem "opaque", "unclear", and "arbitrary".

decision making by highlighting key adjudicative considerations consistent with the objective/principle of a particular legislative and/or policy requirement."<sup>19</sup> While policies, guidelines, practice directions, and similar documents do not bind administrative decision makers, they provide guidance to decision makers to improve consistency between decisions.

## REPRESENTATIVES REPORTED

Representatives overwhelmingly reported that the lack of information published by the Mental Health Review Board made the tribunal's functions and internal operating decisions seem "opaque", "unclear", and "arbitrary". Several representatives observed that when compared to other administrative bodies they work with, the absence of policies, guidelines, practice directions, accountability documents, and annual reports made the Mental Health Review Board one of the most inconsistent and confusing tribunals to represent clients before. Representatives reported that they often heard anecdotally or second hand that the Mental Health Review Board Chair had communicated a new policy or shared an opinion about legal interpretation with review panel members that was not publically available. Representative feedback presented throughout this report has highlighted several significant issues that could be improved with policies, guidelines, or practice directions, such as variable and unfair hearing procedures and inconsistent applications of *Mental Health Act* criteria in review panel decisions.

In addition, representatives reported that it would be useful to see the following information published by the Mental Health Review Board in an annual report or another format:

- The number of applications for review panels received annually.
- The number of review panel hearings held annually.
- A breakdown of the number of applications received and the number of hearings held annually compared by facility, region, or health authority.
  - Several representatives had observed variable trends in requests for review panels from particular facilities, for example, a certain facility from which there are regular applications made for review panels would abruptly have no requests for review panels for a stretch of several months. Information of this nature could be a useful flag for health authorities and the Ministry of Health that there are problems with the provision of rights information in that facility.
  - Some representatives were under the impression that even taking into consideration lower population rates, there were substantially fewer review panels held in rural areas,

<sup>19</sup> WorksafeBC, Practice Directives, online: <<https://www.worksafebc.com/en/law-policy/claims-rehabilitation/practice-directives>>.

which raises the concern that detainees in rural areas face more barriers in exercising their right to a review panel.

- The tribunal's timelines for scheduling a hearing once the request for the review panel has been received.
  - Some representatives reported that it appeared that the tribunal took longer to schedule panels in more remote regions of the province.
- The tribunal's policies, guidelines, and average timelines for rescheduling a postponed hearing.
- The breakdown of hearing outcomes annually.
  - Some representatives pointed out that in the absence of any published decisions, it would be useful to see a breakdown from the tribunal of what criterion resulted in discontinuation of detention to improve understanding of what grounds detainees are discharged on.
- The rates of hearing outcomes broken down by decision maker.
  - The Mental Health Review Board used to publish the outcomes of hearings broken down by decision maker, but no longer does. Several representatives were under the impression that some panel members almost never voted for discontinuation of detention. Lawyers who practice in the area of immigration law reported that the breakdown of acceptance rates for refugee applications by individual tribunal members had been important and useful information in the immigration context.
- The number of hearings in which videoconference and teleconference technology is used.
- The challenges associated with and efforts made in obtaining an adequate physical location in detaining facilities for hearings to take place in.
- The number of detainees who are unrepresented at hearings and what impact, if any, that has on hearing outcomes.
- The scope and content of training provided to new tribunal members.
- The scope and content of ongoing professional development provided to existing tribunal members.
- Methods and efforts made by the Mental Health Review Board to evaluate and measure performance, accountability, and accomplishments.
  - Some representatives specifically raised questions about how the tribunal internally measures how they are fully and fairly achieving their legislative mandate in the absence of any judicial reviews or other legal developments.
- Methods and efforts made by the Mental Health Review Board to create consistent interpretation of the *Mental Health Act* criteria among tribunal members in the absence of published decisions, policies, and guidelines.
- Identification of trends and issues in review panel hearings.
- Education or outreach efforts made by the Mental Health Review Board to detaining facilities, detainees, and the public.
- The number of review panel hearings that are delayed or prolonged as a result of detaining facilities failing to conduct pre-hearing disclosure and the costs associated with such delays.

- The number of file reviews the Chair conducts pursuant to s. 25(1.1) of the *Mental Health Act* for detainees who have been on extended leave for more than 12 consecutive months without requesting a review panel hearing and the number of hearings that are ordered as a result of such file reviews.
- Disclosure of financial information and operating costs of the Mental Health Review Board.
  - A few representatives expressed specific interest on the costs expended by the tribunal in compensating case presenters for presenting the state's case for detention at review panels.

## CONCLUSION AND RECOMMENDATIONS

Documents published by administrative tribunals, such as policies, guidelines, practice directions, accountability frameworks, and annual reports, are not merely paperwork. They are the way the tribunal communicates with the responsible minister, the public and—most critically—the parties who appear before it. They are an integral component in ensuring that decisions made by the tribunal Chair, members, and support staff are fair, predictable, consistent, and impartial. In the words of Chief Justice McLachlin, “[f]air procedures, equitable treatment, and responsiveness to the public are the cornerstones of a system of administrative tribunals built according to the Rule of the Law.”<sup>20</sup> Decisions regarding hearing schedules, procedures, and outcomes should be based on transparent and consistently applied factors, not on which individual you happen to speak to that day. It is clear both from representatives’ experiences discussed throughout this report, as well as tribunal document reviews, that the Mental Health Review Board has fallen significantly short of the standards expected of administrative tribunals. Given the significance of the *Charter* rights engaged, detainees are legally entitled to a high degree of procedural fairness and transparent, consistent, and impartial decisions.

The **Mental Health Review Board** should comply with its legal obligation to produce an annual report in accordance with s. 59.2 of the *Administrative Tribunals Act*. The **Mental Health Review Board** should also produce rules, policies, guidelines, or practice directions in consultation with stakeholders to address inconsistencies in procedures and the substantive application of the *Mental Health Act*.

<sup>20</sup> Beverley McLachlin, “The Roles of Administrative Tribunals and Courts in Maintaining the Rule of Law” (1999) 12 Can. J. of Admin. L. and Prac., 171 at 186.

## SUMMARY OF RECOMMENDATIONS

### TRANSPARENCY AND ACCOUNTABILITY OF MENTAL HEALTH REVIEW BOARD

For the Mental Health Review Board:

- **Comply with the legal obligation to produce an annual report.**
- **Produce rules, policies, guidelines, or practice directions to address inconsistencies in procedures and the substantive application of the *Mental Health Act*.**

## INADEQUATE TRANSPARENCY AND ACCOUNTABILITY OF MINISTRY OF HEALTH AND HEALTH AUTHORITIES

In BC, the Ministry of Health works together with health authorities to provide health care services, including detention and involuntary psychiatric treatment pursuant to the *Mental Health Act*. There are five regional health authorities that govern, plan and deliver health care services within their geographic areas: Fraser Health, Interior Health, Island Health, Northern Health, and Vancouver Coastal Health. The First Nations Health Authority plans, designs, manages, and funds the delivery of First Nations health programs and services in BC. Finally, the Provincial Health Services Authority oversees the co-ordination and delivery of provincial programs and specialized health care services. For example, the Provincial Health Services Authority is responsible for BC Children's Hospital, where children may be detained under the *Mental Health Act*.

While this report was in the final stages, a new BC Government was formed, which established a new ministry—the Ministry of Mental Health and Addictions. At the time this report is published, it is still unclear what the respective mandates and roles of the Ministry of Health and the new Ministry of Mental Health and Addictions will be. Regardless of the composition of the ministries of the day, the BC Government is ultimately responsible for leadership and oversight of the administrative system for mental health detention in this province.

### REPRESENTATIVES REPORTED

Many representatives expressed that there was insufficient transparency and reporting from the health authorities and the Ministry of Health to enable effective evaluation of the state of *Mental Health Act* detention in BC. Although representatives stated that some of the information that they would like to see may be published among population data or in fragmented pieces among documents like annual service plan reports, there was no centralized and coherent reporting on *Mental Health Act* detentions specifically. Several representatives reported that insufficient monitoring and evaluation of the fairness of the administrative system for *Mental Health Act* detention demonstrated a disregard of detainee's *Charter* rights.

*"The Ministry sets out protections under the Act ... they don't track them, they don't measure them, they don't know if they're used, they don't know how effective they are. There's never been any adjustments since they were brought in, so you know, what kind of conclusion can you draw from that? ... That's paternalism."*

Representatives reported that it would be useful to see the following information on *Mental Health Act* detentions published by the Ministry of Health and the health authorities:

- The number of involuntary and voluntary *Mental Health Act* admissions in BC annually.
  - Many representatives also made inquiries about detention statistics compared by facility, region, or health authority.
  - Some representatives expressed interest in seeing involuntary admission statistics broken down by *Mental Health Act* provisions, for instance, the number of individuals admitted pursuant to s. 22 involuntary admissions, s. 28 emergency procedures, s. 29 prisoners and youth custody centre inmates, or s. 42 transfers from another province.

## IN THE WORDS OF THE LEGAL REPRESENTATIVES:

“The Ministry sets out protections under the Act ... they don’t track them, they don’t measure them, they don’t know if they’re used, they don’t know how effective they are. There’s never been any adjustments since they were brought in, so you know, what kind of conclusion can you draw from that? ... That’s paternalism.”

- The length of detention periods.
  - Many representatives expressed concern about individual detainees who they had encountered who have “fallen through the cracks” and been detained and subject to forced psychiatric treatment for prolonged periods of time with no plan to facilitate their return to community or transfer them to a less restrictive setting.
- The demographics of detainees.
- The type of diagnoses of detainees.
  - Several representatives pointed out that although it was generally assumed that the *Mental Health Act* is primarily used to detain individuals with major mental health diagnoses like schizophrenia and bipolar disorder, it seemed like the *Mental Health Act* was being used in an increasing variety of situations. For example, representatives reported representing seniors with dementia or Parkinson’s disease who were detained to provide physical health care or individuals with substance use problems, acquired brain injuries, and developmental disabilities.
- The number of individuals who seek and are refused voluntary admission pursuant to the *Mental Health Act*.
  - Some representatives observed a paradox in that many individuals who come to hospitals seeking mental health services through voluntary admission are turned away, whereas many individuals who do not want to remain in hospital are involuntarily admitted. These representatives commented that this trend may indicate that our mental health care system is set up in an adversarial way in which health care providers are more likely to see the need for intervention when an individual is not seeking assistance.
- The number of illegal detentions that occur annually because the initial certification was not appropriately completed or the certificates unintentionally lapsed without renewal.
- The number of detainees placed on extended leave, the length of extended leave periods, the conditions detainees are obligated to follow on extended leave, and the number of detainees recalled from extended leave.
- The methods and efforts that the Ministry of Health and health authorities engage in to monitor the safety, efficacy, and duration of forced psychiatric treatment.
  - Many representatives raised concerns about the lack of oversight of the psychiatric treatment decisions made by physicians on behalf of their patients, which results in a great deal of variety in psychiatric treatment depending on the individual psychiatrist



or detaining facility. Others expressed concern that there were individuals who had been effectively warehoused in facilities for years receiving forced psychiatric treatment that was producing no benefit to mental health symptoms. Several examples of this were discussed in section 4 | [Psychiatric Treatment](#).

- Some representatives expressed interest in seeing the status of research on the safety and efficacies of psychiatric treatment methods, such as Electroconvulsive Therapy, early intervention programs, addictions treatment methods, and treatment methods that do not rely on psychotropic pharmaceutical agents.
- The number of second medical opinions requested by detainees pursuant to s. 31(2), the timelines for second opinions to be obtained, who conducts second medical opinions, how often second opinions differ from the course of treatment, and how often a divergent second opinion results in a change to the course of treatment.
- The number of detainees placed in restraints or seclusion, the reasons for restraints or seclusion use, the length of time restraints and seclusion were used for, and the methods and efforts the Ministry of Health and health authorities engage in to monitor use of restraints and seclusion.
- Information regarding the training and methods of health care providers delegated with the responsibility of providing rights information pursuant to s. 34 of the *Mental Health Act*.
  - For example, many representatives expressed interest in the timing of rights information provision and how soon following detention rights information is provided.
- The methods and efforts that the Ministry of Health and health authorities engage in to monitor the provision of rights information.
  - Many representatives had several questions about how the provision of rights information is tracked and evaluated, for example, how often health care providers repeat rights information pursuant to s. 34(3) because a detainee did not understand the rights information initially provided or how often health care providers fulfill the obligation of providing a detainee copies of their certificates documenting the reasons for detention.
- The number of detainees who make requests to speak to a lawyer to obtain legal advice about detention, to pursue a s. 33 statutory *Mental Health Act* application, to pursue a *habeas corpus* application, or to pursue a judicial review application and what efforts health care providers engage in to facilitate access to a lawyer.
- Information regarding training of health care providers who are responsible for pre-hearing disclosure and presenting the state's case for detention at review panel hearings.
- The methods and efforts the Ministry of Health and health authorities engage in to ensure facilities fulfill their legal obligations to carry out disclosure of records in legal proceedings, such as review panels.

- Information on complaint mechanisms available to detainees, such as the names and contact information of directors responsible for designated facilities.
- The number of complaints made by detainees to patient care quality review boards within health authorities and the Ministry of Health and the efforts engaged in to address the complaints.

## CONCLUSION AND RECOMMENDATIONS

The health authorities and Ministry of Health do not track and publish the most basic information necessary to oversee *Mental Health Act* detentions and forced psychiatric treatment. The Ministry of Health does not have comprehensive and current data on straightforward components of the mental health detention system, such as the number of detentions broken down by facility, geographic region, or health authority; the average length of detention periods; the average length of extended leave periods; the number of involuntary patients recalled from extended leave; the diagnoses made of detained individuals; the number of second medical opinions requested by detainees; and the use of restraints and seclusion during detention.<sup>21</sup> It is impossible to engage in an effective analysis of how the mental health detention system is operating in the absence of the information necessary to conduct an evaluation. The obvious conclusion to be drawn from the failure to track and monitor this data is that the health authorities and the Ministry of Health have not been engaging in oversight or evaluation of the system for mental health detention in BC.

The **Ministries of Health and Mental Health and Addictions should work in conjunction with the health authorities** to create mechanisms to track and evaluate the functions of the *Mental Health Act* detention system, such as the indicia identified by the representatives in this report.

<sup>21</sup> According to information provided in response to a Freedom of Information request to the Ministry of Health submitted on July 27, 2017, which is overdue and therefore has not been made public on the Open Information Catalogue website at the time this report was published.

## SUMMARY OF RECOMMENDATIONS

### TRANSPARENCY AND ACCOUNTABILITY OF MINISTRY OF HEALTH AND HEALTH AUTHORITIES

For the Ministries of Health and Mental Health and Addictions in conjunction with the health authorities:

- Create mechanisms to track and evaluate the functions of the *Mental Health Act* detention system.

## INADEQUATE SYSTEMIC REVIEW AND INACCESSIBLE COMPLAINT MECHANISMS

The BC Government has failed to engage in systemic review of the administrative system for *Mental Health Act* detention and involuntary psychiatric treatment. While different Canadian jurisdictions have taken various approaches, most have taken the initiative to put some form of systemic investigation or oversight in place given the significant rights infringed in mental health detention. For example, the Alberta *Mental Health Act* has created a statutorily protected independent Mental Health Patient Advocate Office. Its role is to “investigate complaints from or relating to formal patients or persons who are subject to community treatment orders and exercise any other powers and perform any other duties that are prescribed in the regulations.”<sup>22</sup> In Ontario, the Psychiatric Patient Advocate Office has a mandate that includes advancing the legal and civil rights of patients through systemic advocacy and investigating alleged incidents to assess institutional and systemic responses to these instances.<sup>23</sup>

Several Canadian jurisdictions have commissioned investigations to evaluate whether their involuntary mental health systems are functioning effectively and minimally impairing the rights of those impacted. Many jurisdictions in fact mandate through legislation that reviews must take place periodically. For example, the Nova Scotia government appointed a former Supreme Court of Canada judge, Justice Gérard La Forest, to chair an independent review of its system of mental health detention and involuntary psychiatric treatment, which resulted in the comprehensive Report of the Independent Panel to Review the Involuntary Psychiatric Treatment Act and Community Treatment Orders.<sup>24</sup> Ontario has commissioned multiple independent reviews of components of its mental health system, including the 2005 Report on the Legislated Review of Community Treatment Orders<sup>25</sup> and the 2012 report, The Legislated Review of Community Treatment Orders.<sup>26</sup> The Research and Evaluation Department of the Newfoundland and Labrador Centre for Health Information conducted a review of the Newfoundland and Labrador mental health detention system in the 2012 Mental Health Care and Treatment Act Evaluation Final Report.<sup>27</sup>

The Office of the Ombudsperson has the mandate in BC to investigate whether provincial public authorities have acted fairly and reasonably. The last published systemic investigation that considered mental health detention in depth was the 1994 *Listening* investigation of Riverview Hospital, which has been discussed throughout this report. The Ombudsperson also found fairness violations in the brief consideration given to *Mental Health Act* detention issues for seniors in the 2012 report, *The Best of Care*. In that investigation, the Ombudsperson found that the “health authorities’ use of sections 22 and 37 of the *Mental Health Act* to involuntarily admit seniors to mental health facilities and then transfer them to residential care is done without clear provincial policy to ensure that the Act is used as a last resort and that seniors are

22 R.S.A. 2000, c. M-13, s. 45.

23 Psychiatric Patient Advocate Office, “Mandate of the PPAO”, online: <[http://www.sse.gov.on.ca/mohltc/ppao/en/Pages/AboutthePPAO/MandateandHistory\\_C.aspx?openMenu=smenu\\_MandateandHistory](http://www.sse.gov.on.ca/mohltc/ppao/en/Pages/AboutthePPAO/MandateandHistory_C.aspx?openMenu=smenu_MandateandHistory)>.

24 Minister of Health and Wellness, “Report of the Independent Panel to Review the *Involuntary Psychiatric Treatment Act* and Community Treatment Orders”, by Gérard V. La Forest and William Lahey (Halifax: Minister of Health and Wellness, submitted 10 July 2013), online: <<https://novascotia.ca/dhw/mental-health/reports/IPTA-Review-2013.pdf>>.

25 Ontario Ministry of Health and Long-Term Care, “Report on the Legislated Review of Community Treatment Orders, Required Under Section 33.9 of the *Mental Health Act*”, online: <<http://www.ontla.on.ca/library/repository/mon/17000/270414.pdf>>.

26 Ontario Ministry of Health and Long-Term Care, “The Legislated Review of Community Treatment Orders”, prepared by R.A. Malatest & Associates (Toronto, 23 May 2012), online: <[http://www.health.gov.on.ca/en/public/programs/hepatitis/docs/cto\\_review\\_report.pdf](http://www.health.gov.on.ca/en/public/programs/hepatitis/docs/cto_review_report.pdf)>.

27 Newfoundland and Labrador Centre for Health Information, “Newfoundland and Labrador Mental Health Care and Treatment Act Evaluation Final Report,” (April 2012), online: <[http://www.health.gov.nl.ca/health/mentalhealth/MHCTA\\_Final\\_EVALUATION\\_Report.PDF](http://www.health.gov.nl.ca/health/mentalhealth/MHCTA_Final_EVALUATION_Report.PDF)>.

not unnecessarily deprived of their civil liberties.”<sup>28</sup> In addition, the investigation discovered that health authorities were inappropriately charging individuals fees without legislative authority to do so when they have been involuntarily detained in mental health facilities under the *Mental Health Act* and then transferred to residential care facilities.<sup>29</sup>

In conducting its 1994 *Listening* investigation of Riverview Hospital, the Ombudsperson expressed concern about the significant challenges that exist for mental health patients to access oversight mechanisms that are complaint driven, such as internal complaints in the hospital and external complaints to the Ombudsperson. The Ombudsperson concluded that there was a “significant gap in advocacy, both for patients of Riverview Hospital and clients of mental health services in B.C. generally.”<sup>30</sup> It recommended that the government establish a provincial Mental Health Advocate who would engage in systemic mental health advocacy, report publically on advocacy issues, and provide research, information and referral services to support advocacy services.<sup>31</sup>

The Minister of Health gave effect to this recommendation in appointing Nancy Hall as the first provincial Mental Health Advocate on August 6, 1998.<sup>32</sup> The Advocate’s role was to “monitor the performance of the mental health system and make recommendations about services and programs for people with the most serious mental illnesses.”<sup>33</sup> The office of the Advocate was launched in October 1998 and soon after published the annual report, *Pump Up the Volume: A Report from the Mental Health Advocate of BC*, which focused on improving dignity for people with mental illness, creating uniform standards of mental health care among the regional health authorities, and stronger management and cooperation on mental health issues among government ministries.<sup>34</sup> The following year, the Advocate published *Growing the Problem: The Second Annual Report of the Mental Health Advocate of British Columbia*, which expressed alarm that a growing number of *Mental Health Act* detainees were denied their right to representation at review panel hearings, identified a lack of clear complaints processes for *Mental Health Act* detainees who experienced significant rights violations in the involuntary commitment processes, and documented a growing reliance on the extended leave provisions of the *Mental Health Act*, with

The BC Government abruptly eliminated the office of the independent provincial Mental Health Advocate in 2001 despite recommendations that the office should be maintained.

28 British Columbia, Office of the Ombudsperson, *The Best of Care: Getting it Right for Seniors in British Columbia*, Part 2, Public Report No. 47 (February 2012) at 173, online: <<https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2047%20The%20Best%20of%20Care-%20Getting%20it%20Right%20for%20Seniors%20in%20BC%20%28Part%202%29%20Overview.pdf>>.

29 *Ibid* at 97, 174.

30 *Listening* at 10-1.

31 *Ibid* at 10-7.

32 Ministry of Health and Ministry Responsible for Seniors, “Mental Health Advocate Appointed”, *News Release* (6 August 1998), 1998:135.

33 *Ibid*.

34 The Mental Health Advocate of BC, *Pump up the Volume: A Report from the Mental Health Advocate of BC* (Victoria: the Mental Health Advocate of British Columbia).

inadequate data provided by designated facilities to the Ministry to enable effective review of the use of extended leave.<sup>35</sup>

The *Report of the Evaluation of the Role of the Mental Health Advocate for British Columbia*, published by an independent management consultant on December 28, 1999, concluded that the office should be retained as a systemic advocacy office. The researcher identified that the value of the Mental Health Advocate was in monitoring the 'state' of the system, hearing and synthesizing individual complaints, identifying systemic themes requiring action, and proposing courses of action and recommendations to improve the system.<sup>36</sup> Despite these findings, the BC Government decided to close the office of the Mental Health Advocate in 2001. In a statement released on November 23, 2001, Nancy Hall said:

*By now you will know that the Ministry of Health Services has decided to close the Office of the Mental Health Advocate on November 30. The new Minister of State for Mental Health has told me he is now the Advocate, and from now on people who would have called our Office for support (over 3000 during the last 3 years) are to call the Mental Health Division in the Ministry of Health Services.*

*While I respect the fact that government has made a decision, obviously it is not a decision that I agree with, having spent the past 3 years assisting individuals who have a demonstrated difficulty in being treated respectfully in "normal" procedural channels and who have, in many cases, a deep distrust of government.*

In the absence of systemic investigations, the onus is on individuals to initiate and sustain a complaint following a negative experience with mental health detention.

## REPRESENTATIVES REPORTED

In the absence of systemic investigations, the onus is on individuals to initiate and sustain a complaint following a negative experience with mental health detention. Most representatives reported that they were not aware of effective and accessible complaint mechanisms to refer clients to when they had a negative experience while detained under the *Mental Health Act*. As with many aspects of detention, representatives reported that internal complaint processes seemed to vary greatly across facilities and health authorities. One representative reported a positive experience with a patient care quality review board which responded effectively to a situation in which a physician had inappropriately refused to discharge a senior with mild dementia and physical health problems after the review panel had ordered her discharge. However, the majority of representatives reported that facilities did not provide sufficient information on internal complaint processes to make them accessible to detainees and that the few detainees who did access these internal processes did not receive an effective response.

<sup>35</sup> *Growing the Problem: The Second Annual Report of the Mental Health Advocate of British Columbia January 1 — December 31, 2000* (Victoria: the Mental Health Advocate of British Columbia).

<sup>36</sup> *Report of the Evaluation of the Role of the Mental Health Advocate for British Columbia*, by Dr. Nick Poushinsky (Vancouver: 28 December 1999) at 8.

Some representatives reported that they had also referred detainees to external complaint bodies when detainees had experienced an administrative fairness violation or other negative experience, such as the Ombudsperson<sup>37</sup> or the College of Physicians and Surgeons. However, these representatives pointed out that there are many barriers for detainees to access these complaint driven mechanisms. It is challenging for detainees to learn about these external investigating bodies and understand what their mandates and functions are. However, even once aware of these complaint mechanisms, it can be very difficult for detainees to access the practical tools necessary to make a complaint, such as a phone, a computer, or a pen and paper. It is also difficult for someone who is experiencing mental health problems or negative feelings as a result of an involuntary detention, while under the influence of psychotropic pharmaceutical agents, to sustain the focus necessary to conceptualize and organize their complaint, present the complaint in a way that others will understand, file the complaint, and participate in the complaint process. The representatives who had referred detainees to external complaint bodies reported that very few detainees had followed through on accessing these complaint mechanisms, and even fewer received a satisfactory response, even when the complaint had substantial merit.

## CONCLUSION AND RECOMMENDATIONS

Placing the onus on *Mental Health Act* detainees to initiate individual complaints has a number of significant disadvantages. Representatives reported several barriers to individuals accessing complaint mechanisms after a negative experience with mental health detention. Even when individuals overcome these barriers and successfully make a complaint, they may not be believed, they may not be able to participate in the ongoing complaint process, and a piecemeal approach to individual complaints may do nothing to address the systemic issues. *Mental Health Act* detainees are in a position of powerlessness—the mental health detention system has taken away their freedom, their bodily integrity, their right to make decisions, and in many circumstances, their voice. Those responsible for administering this system must take proactive steps to rigorously monitor the extraordinary exercise of power over detainees.

BC's system of *Mental Health Act* detention is operating in darkness. The rights violations and procedural unfairness identified throughout this report have flourished in the absence of systemic oversight and evaluation. BC has fallen far behind other Canadian jurisdictions on numerous measures—our substantive law is not constitutionally compliant, our procedures are inadequate to provide effective safeguards, and our systemic review efforts are virtually non-existent. The BC *Mental Health Act* and the *Mental Health Regulation* are outdated, deeply flawed, and inadequate to fulfill the rights guaranteed by the *Charter* and the UN CRPD.

The only way to address these deeply entrenched flaws is to shine a bright and intense light on the system of *Mental Health Act* detention. The *Mental Health Act* detention

BC's system of *Mental Health Act* detention is operating in darkness. The rights violations and procedural unfairness identified throughout this report have flourished in the absence of systemic oversight and evaluation.

<sup>37</sup> Correspondence to and from a detainee must be transmitted unopened pursuant to the *Ombudsperson Act*, R.S.B.C. 1996, c. 340, ss. 12(3), (4).



The only way to address these deeply entrenched flaws is to shine a bright and intense light on the system of *Mental Health Act* detention. The *Mental Health Act* detention system does not just need a few amendments or tweaks, it needs to be overhauled.

## SUMMARY OF RECOMMENDATIONS

### SYSTEMIC REVIEW

#### For the BC Government:

- Establish an independent law reform commission to conduct a comprehensive review of the BC system for *Mental Health Act* detentions and forced psychiatric treatment.
- Reinstatement of the independent provincial Mental Health Advocate.

#### For the Office of the Ombudsperson:

- Review the scope of the current systemic investigation of the BC system for *Mental Health Act* detentions and forced psychiatric treatment.

system does not just need a few amendments or tweaks, it needs to be overhauled. The **BC Government** should provide the necessary resources, mandate, and investigatory powers to an independent law reform commission to conduct a comprehensive review of the BC system for *Mental Health Act* detentions and forced psychiatric treatment.

The **Office of the Ombudsperson** recently initiated a systemic investigation which may address some of the fairness concerns identified throughout this report in the system for *Mental Health Act* detention and forced psychiatric treatment, however the scope of the investigation is not yet known.

Finally, given the longstanding failures of the responsible authorities in proactively monitoring themselves, the BC Government should appoint a provincial Mental Health Advocate who is independent of any government ministry and reports directly to the legislative assembly. In the last 15 years since the Mental Health Advocate's role was abruptly eliminated, our mental health system has stagnated in the dark. The **BC Government** should appoint a provincial Mental Health Advocate with adequate resources and an appropriate mandate who is independent of any government ministry and reports directly to the legislative assembly. The reinstatement of a provincial Mental Health Advocate to act as an independent watchdog would demonstrate the BC Government's commitment to move forward to a mental health system that fulfills the principles of dignity, equality, and self-determination.

# Summary of Recommendations

*Recommendations are set out in detail in the relevant section of the report.*

## FOR THE BC GOVERNMENT

### 1 | Detention Decisions:

- Review and amend the *Mental Health Act* definition of “examination” for the purposes of detention, including in-person assessments.

### 2 | Restraints and Seclusion:

- Review and amend the *Mental Health Act* to create legal criteria that governs the use of restraints and seclusion with detainees.
- Review and amend the *Mental Health Act* to establish clear criteria governing the right to wear clothes and the right to same sex clothing removal.

### 3 | Access to Information and Legal Advice:

- Review and amend the *Mental Health Act* to create a statutory framework for prompt, independent rights advice on detention and detention renewal.
- Review and amend the *Mental Health Act* to address detainees’ rights to communication, in person access, and privacy.

### 4 | Psychiatric Treatment:

- Review and amend the deemed consent model to establish equal health care consent rights for physical and mental health care decisions.

- Review and amend the *Mental Health Act* and *Mental Health Regulation* regarding documentation and authorization of psychiatric treatment.

- Review and amend the *Mental Health Act* and *Mental Health Regulation* to establish adequate oversight mechanisms of psychiatric treatment.

### 5 | Scheduling and Preparing for a Review Panel Hearing:

- Review and amend the *Mental Health Act* to ensure legal reviews of detention take place at certain periodic intervals for all detainees.

### 6 | Review Panel Hearings and Decisions:

- Review and amend the *Mental Health Act* to prioritize the appointment of community members with lived experience of mental illness to the Mental Health Review Board.
- Review and amend the *Mental Health Act* to create protections against conflict of interest, bias, and the apprehension of bias among review panel members.
- Review the current structure and consider creating a new role for a lawyer or another individual with adequate legal training to present the case for detention.

## 7 | Oversight and Accountability:

- Review and amend the *Mental Health Act* and related statutes to create an independent administrative body that provides effective oversight of the conditions of detention.
- Review the *Mental Health Act* to consider an amendment to grant an independent administrative body jurisdiction to order that detaining facilities pay a minimum amount of compensation to wrongfully detained individuals.
- Review and amend the *Mental Health Act* to create a statutory framework for prompt, independent rights advice.
- Establish an independent law reform commission to conduct a comprehensive review of the BC system for *Mental Health Act* detentions and forced psychiatric treatment.
- Reinstate the independent provincial Mental Health Advocate.

## FOR THE MENTAL HEALTH REVIEW BOARD

### 2 | Restraints and Seclusion:

- Create a rule that detainees have the right to wear clothes during review panel hearings.

### 5 | Scheduling and Preparing for a Review Panel Hearing:

- Eliminate rule 7.1 that precludes detainees who have cancelled a hearing from requesting a hearing until the next certification period.
- Address the process and timelines for rescheduling postponed hearings.
- Address the process for implementing *Mental Health Act*, s. 25(1.1).
- Establish timelines for detaining facilities and mental health teams to conduct pre-hearing disclosure.

- Ensure that panel members grant detainees a reasonable recess to review evidence presented by detaining facilities that did not form part of the pre-hearing disclosure.

### 6 | Review Panel Hearings and Decisions:

- Amend the Rules of Practice and Procedures or produce policies or guidelines to address bias and the apprehension of bias among review panel members.
- Stop the practice of funding detaining facilities to prepare and present expert evidence and participate in review panels or start providing equivalent funding to detainees.
- Improve initial training and ongoing professional development for review panel members.
- Establish clear hearing procedures in which parties are permitted a full opportunity to present their case.
- Address the issue of observers and support people attending review panel hearings.
- Establish parameters for detaining facilities to ensure that hearings take place in appropriate physical locations.
- Address consistent interpretation of the legal criteria for detention.
- Develop a consistent and transparent policy regarding the internal process for reviewing the draft reasons of review panel members.
- Publish anonymized review panel decisions.

### 7 | Oversight and Accountability:

- Provide information to detainees regarding their options for challenging review panel decisions when delivering written reasons for the decision.
- Comply with the legal obligation to produce an annual report.
- Produce rules, policies, guidelines, or practice directions to address inconsistencies in procedures and the substantive application of the *Mental Health Act*.

## FOR THE MINISTRIES OF HEALTH AND MENTAL HEALTH AND ADDICTIONS IN CONJUNCTION WITH THE HEALTH AUTHORITIES

### 1 | Detention Decisions:

- Create standardized provincial policies and training for physicians making detention decisions to address illegible or inadequate reasons for detention and inconsistent or inappropriate application of the detention criteria.
- Remove requirements for involuntary status under the *Mental Health Act* as a prerequisite for receiving mental health care and services.
- Create standardized provincial policies and training regarding best practices for detention examinations, including in-person assessments.
- Create standardized provincial policies and training for physicians responsible for detention decisions to address current problems, such as the failure to discharge detainees who no longer meet the legal criteria for detention.

### 2 | Restraints and Seclusion:

- Expand and update standardized provincial policies and training regarding the use of restraints and seclusion to address current problems, such as seclusion use as a disciplinary measure or for staff convenience.
- Create standardized provincial policies and training on the issues of clothes and clothing removal for detainees.

### 3 | Access to Information and Legal Advice:

- Create standardized provincial policies and training for health care providers who provide rights information to detainees.
- Create standardized provincial policies and training to ensure that health care providers respect detainees' rights to communication, in person access, and privacy to address problems such as breaching detainees' legally privileged communications.

### 4 | Psychiatric Treatment:

- Create standardized provincial policies and training regarding documentation and authorization of psychiatric treatment to address problems such as using rubber stamps rather than documenting the psychiatric treatment administered.
- Create standardized provincial policies and training to ensure that health care providers understand and respect detainees' rights to timely and independent second medical opinions.

### 5 | Scheduling and Preparing for a Review Panel Hearing:

- Create standardized provincial policies and training to correct the current practice of some detaining facility staff in offering inducements, making threats, exerting pressure, and actively interfering with detainees exercising their legal right to seek review of their detention.
- Create standardized provincial policies and training for facility directors in monitoring detention lengths to fulfill *Mental Health Act*, s. 25(1.1).
- Create standardized provincial policies and training to correct the widespread inconsistencies and deficiencies in fulfilling pre-hearing disclosure obligations among detaining facilities and mental health teams.

### 6 | Review Panel Hearings and Decisions:

- Create standardized provincial policies and training that address the attendance of health care providers as observers at review panel hearings and appropriate physical locations for scheduling review panel hearings.
- Create standardized provincial policies and training for health care providers responsible for presenting the case for detention at review panels.

### 7 | Oversight and Accountability:

- Create mechanisms to track and evaluate the functions of the *Mental Health Act* detention system.

*Mental Health Act* detainees are in a position of powerlessness — the mental health detention system has taken away their freedom, their bodily integrity, their right to make decisions, and in many circumstances, their voice. Those responsible for administering this system must take proactive steps to rigorously monitor the extraordinary exercise of power over detainees.

## FOR THE LEGAL SERVICES SOCIETY

### 3 | Access to Information and Legal Advice:

- Provide funding for detainees to access legal advice on detention and detention renewal.

### 7 | Oversight and Accountability:

- Provide funding for detainees to obtain legal representation to pursue s. 33 statutory applications, *habeas corpus* applications, and judicial reviews of review panel decisions.

## FOR THE OFFICE OF THE OMBUDSPERSON

### 7 | Oversight and Accountability:


- Review the scope of the current systemic investigation of the BC system for *Mental Health Act* detentions and forced psychiatric treatment.

## APPENDIX

# FOI Response

Also available online at [http://docs.openinfo.gov.bc.ca/Response\\_Package\\_HTH-2017-70893.pdf](http://docs.openinfo.gov.bc.ca/Response_Package_HTH-2017-70893.pdf)

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### Mental Health Hospitalizations in BC

#### Involuntary and Voluntary Admissions

2005/06 - 2015/16

*Client:*

*Author:* **Tony Wang**


*Project #:* **2017\_0334** *Please reference the project # when making inquiries about this report.*

*Filename:* **Hospital Discharges with MH Diagnosis Treated Involuntarily 2005-2015 - Media Reque**

*Source:* **DAD**  
Data extracted on March 29, 2017

<i>Tabs:</i>	<b>Cover Page</b>	
	<b>Notes</b>	
	<b>Uniq</b>	Unique count of patients with the mental health diagnoses
	<b>Cases</b>	Case counts of patients with the mental health diagnoses
	<b>Unique Extended Leave</b>	Unique count of patients on released on extended leave.

*Privacy Statement:* The information contained in this/these spreadsheet(s) is of a summary nature and may be released in its entirety (Cover Sheet and relevant Tabs) for the purpose for which it was provided. However, as it was prepared to address a specific question, other use or manipulation of the data is not permitted.



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Notes



# **Mental Health Hospitalizations in BC Involuntary and Voluntary Admissions 2005/06 - 2015/16**

Project: **2017\_0334**

Filename: **Hospital Discharges with MH Diagnosis Treated Involuntarily 2005-2015 - Media Request.xlsx**

Source: **DAD**

Data extracted on March 29, 2017

**Notes: All relevant notes and criteria**

- 1 Care level are all Acute/Rehab/Day Surgery
- 2 Mental Health diagnoses (Most Responsible Diagnosis only)  
ICD 10 codes: F0, F1, F2, F3, F4, F50, F51, F52, F530, F531, F55, F59, F6, F840, F841, F843, F844, F845, F848, F849, F9, Z281, Z55, Z56, Z57, Z600, Z601, Z603, Z604, Z605, Z608, Z609, Z61, Z62, Z63, Z640, Z641, Z644, Z65, Z720, Z721, Z722, Z723, Z724, Z725, Z726, Z729, Z730, Z731, Z732, Z733, Z734, Z735, Z738, Z739, R410, G312, G442
- 3 BC residents treated out of province are excluded. Non-BC residents are included.
- 4 Riverview Hospital cases with length of stay greater than 180 days are excluded.
- 5 Riverview Hospital did not report project #325-Mental Health Involuntary Admissions before 2008/09.  
Contact with Riverview reveals that almost all the admissions are involuntary. Therefore any admission to this hospital will be regarded as involuntary.
- 6 If the involuntary flag of mental health admission is 'Y', then the case is counted as involuntary; otherwise it would be a voluntary case.
- 7 If a patient is admitted to the hospital several times and if one is involuntary, then this patient is regarded as involuntary in the unique patient table and the hospital of the first hospitalization of the involuntary admission will be recorded.
- 8 Each unknown phn will be regarded as a unique patient.

Uniq

**Mental Health Hospitalizations in BC**  
**Involuntary and Voluntary Admissions**

2005/06 - 2015/16

Unique patient count with the mental health diagnoses

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Admissions	15,792	15,693	15,501	15,284	15,114	14,915	14,724	14,531	14,338	14,145	13,952
Voluntary	15,792	15,693	15,501	15,284	15,114	14,915	14,724	14,531	14,338	14,145	13,952
Total	15,792	15,693	15,501	15,284	15,114	14,915	14,724	14,531	14,338	14,145	13,952

Note: Unique patient counts may have changed from previous reporting due to better patient documentation and data verification.



Business Analytics Strategies and Operations Branch  
Health Sector Information, Analysis and Reporting Division  
Ministry of Health

Last update cycle: 2016 Jan/Feb  
Project No: 2016\_0164  
3 of 6 Hospital Discharges with MH Diagnosis Treated Involuntarily 2005-2015 - ~~Page 3 of 6~~ **Page 3 of 6** HTH-2017-70893

Cases



**Mental Health Hospitalizations in BC**  
**2005/06 - 2015/16**  
**Case count of patients with the mental health diagnoses**

Age Group	Gender	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
0-15	F	15	15	15	15	15	15	15	15	15	15	15
0-15	M	15	15	15	15	15	15	15	15	15	15	15
16-20	F	15	15	15	15	15	15	15	15	15	15	15
16-20	M	15	15	15	15	15	15	15	15	15	15	15
21-45	F	15	15	15	15	15	15	15	15	15	15	15
21-45	M	15	15	15	15	15	15	15	15	15	15	15
46-69	F	15	15	15	15	15	15	15	15	15	15	15
46-69	M	15	15	15	15	15	15	15	15	15	15	15
70+	F	15	15	15	15	15	15	15	15	15	15	15
70+	M	15	15	15	15	15	15	15	15	15	15	15
<b>Total</b>		<b>15</b>	<b>15</b>	<b>15</b>	<b>15</b>	<b>15</b>	<b>15</b>	<b>15</b>	<b>15</b>	<b>15</b>	<b>15</b>	<b>15</b>

Note: Cases with gender other than female or female are coded as total only.

Business Analytics Strategies and Operations Branch  
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 4 Hospital Discharges with MH Diagnosis Treated Involuntarily 2005-2015 - **Measures of Success** 2014-2017-70893

## Unique Extended Leave



**Mental Health Hospitalizations in BC**  
**Number of Patients Involuntarily Admitted and Released on Extended Leave**  
**2008/09 - 2015/16**

No extended leave information is available prior 2008/09

Age Group	GENDER	Fiscal Year										
		2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019
0-30	F	55	73	102	113	154	152	177	211	217	241	241
	M	192	210	275	311	394	414	431	481	481	511	511
0-30 Total		247	283	377	422	548	566	608	692	700	752	752
31-45	F	103	137	151	160	198	195	221	237	241	261	261
	M	148	185	213	239	303	357	445	473	481	511	511
31-45 Total		251	322	364	400	502	552	666	710	722	772	772
46-60	F	119	137	138	187	184	191	233	250	251	261	261
	M	96	115	159	166	208	255	268	282	283	293	293
46-60 Total		215	252	297	353	392	446	501	532	534	554	554
61-75	F	63	62	80	95	111	120	110	144	145	155	155
	M	32	41	48	74	86	100	112	110	111	121	121
61-75 Total		95	103	128	169	197	220	222	254	256	276	276
76+	F	26	29	45	45	53	63	58	78	79	89	89
	M	14	18	19	25	34	41	55	56	57	67	67
76+ Total		40	47	64	70	87	104	113	134	136	156	156
Total		848	1,007	1,228	1,454	1,718	1,927	2,184	2,394	2,412	2,612	2,612

## Notes:

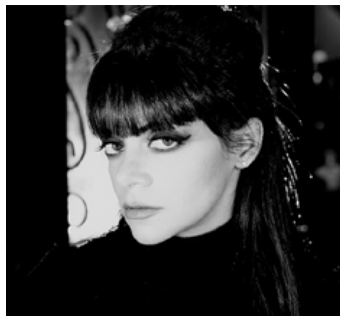
- 1 Cases with gender other than male or female are only counted in total only.
- 2 Age category 0-15 was merged with 16-30 because counts were too small to report
- 3 Unique patient counts may have changed from previous reporting due to better patient documentation and data verification.

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## ABOUT THE PHOTOGRAPHER




**AVA NEUE** is a portrait and art photographer at Division7 Studio, based in Vancouver. Her work has been featured in curated exhibits in Canada and the U.S, as well as in print.

As a survivor of attempted suicide, Ava is all too familiar with what it is like to live with mental health challenges. Life with borderline structure and depression can be hard, but it has also gifted Ava with a sensitivity that enables her to make a deeper connection with life's joy, sorrow, beauty, and triumph. She utilizes her portrait and art photography as a means to register those moments.

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