



Involuntary and Coercive Psychiatric Treatment: A Nursing Response to British Columbia's Mental Health Act

NNPBC aligns with the [Canadian Charter of Rights and Freedoms](#), [United Nations Declaration on the Rights of Indigenous Peoples \(UNDRIP\)](#), [Convention on the Rights of Persons with Disabilities \(CRPD\)](#), and [Convention on the Rights of the Child](#). NNPBC furthermore supports the recommendations provided by BC's Ombudsperson report [Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act](#) and CLASBC's report [Operating in Darkness: BC's Mental Health Act Detention System](#).

NNPBC Position

The [Mental Health Act \(MHA\)](#) authorizes the involuntary treatment of people with mental health issues (MHI) in British Columbia (BC). In the [Guide to the Mental Health Act](#) (2005), the BC Ministry of Health states that without the option of involuntary admission and treatment, people with MHI who do not seek voluntary care will "continue to suffer, causing significant disruption and harm to their lives and the lives of others" (p. 1). The MHA grants substantial power and decision-making authority to health care professionals, including the power to initiate involuntary admission and psychiatric treatment. Nurses of all designations working in all health care settings play a central role in facilitating and supporting psychiatric treatment under this legislation while maintaining the ethical obligation to promote equitable and socially just care. In keeping with NNPBC's mandate of advancing the profession and influencing health and social policy, this position statement will outline key policy positions and a brief background that provides the evidence and reasoning behind these positions.

- BC's MHA, and nursing practice thereunder, should promote the values and human rights guaranteed by the *Canadian Charter* and international human rights instruments. Since involuntary treatment disproportionately impacts certain populations, including indigenous and racialized people, youth, people with developmental disabilities, as well as people who live in poverty and use substances, specific protections should be implemented to ensure ethical, equitable and just care.
- A lack of sufficient voluntary, prevention-based community services, including structural factors (such as the degradation of the social safety net and inadequate access to safe and secure housing) have contributed to an increased reliance on involuntary psychiatric treatment and emergency services/law enforcement. Strengthening and integrating accessible, preventative community mental health services is an urgent nursing priority. Similarly, strengthening the social safety net and addressing core housing needs is mandatory to help prevent mental and physical deterioration and support health and well-being.
- To ensure health care systems meet their obligations as promised to involuntary patients in the MHA, community and acute psychiatric settings must be provided with the resources necessary to provide appropriate care to patients. Supporting meaningful development of existing financial resources, with ongoing training and clinical supervision from practice experts and peers (people with lived experience) is also needed. Optimization of existing resources and increased funding where needs are identified are necessary to support better practice and better health outcomes for the people of BC.
- Nursing codes of ethics recognize that person-centred care is the most effective care (BCCNM, 2010). Person-centered care recognizes that individuals are experts on their own lives with valuable contributions to make in choosing their own path to recovery and well-being. Therefore, involuntary treatment under the MHA should only be used when statutory criteria are met, and all other voluntary mental health and substance use treatment options have been considered. Everyone should receive the most effective, but the least restrictive and intrusive forms of support, assistance and care.



- Nurses play a central role in providing involuntary psychiatric treatment¹. Nurses involved with involuntary psychiatric treatment are at risk for moral distress and burnout due to potential conflicts between person-centred nursing ethics and coercive treatment approaches under the MHA. Therefore, robust policies, procedures, education, and practice supports are required to support nurses' well-being and promote high quality nursing practice in the context of involuntary psychiatric treatment.
- The safety of nurses and the safety of patients are interdependent goals that can, and must, be mutually supported. Ensuring safe psychiatric units, facilities, and health care settings will promote safety for patients and nursing staff. Safe environments are ones that incorporate trauma and violence informed practices, have adequate space, and focus on de-escalation and inclusive decision making over interventions of force and coercion.
- Nurses are committed to transparency and continuous quality improvement. Therefore, nurses support regular review of legislation, regulations, and policies to ensure timely integration of evidence-based best practices, as well as the involvement of peers in policy-making and legislative review.
- Centering the voices and expertise of peers of involuntary and coercive psychiatric treatment is pivotal in nurses' ongoing advocacy towards meaningful systemic change. Therefore, NNPBC supports equitable collaboration with peer leaders and community groups in all of our advocacy work, including appropriate support, education and compensation.
- Nurses play a pivotal role in supporting and facilitating involuntary patients' access to justice, such as informing patients of their rights, access to advocates, as well as ombudsperson resources and information. To fulfill this role, as well as to best advocate for their patients, all nurses should be provided with ongoing, high-quality, training on the Mental Health Act until external rights advisors are an integrated service. Nurses should also ensure that patients are informed of their rights in their primary language via interpretations/sign language.
- The absence of a legal aid funded service for patients to access legal advice when they are detained presents challenges to both nurses and patients, potentially placing nurses in positions which might be perceived as a conflict of interest, or of feeling pressured to give legal advice. Therefore, nurses and nurse leaders support the establishment of a legal aid funded service to provide involuntary patients with independent legal advice from trained legal professionals.
- The NNPBC supports the reinstatement of the Mental Health Advocate to provide independent oversight to the mental health care system and to make recommendations for improvement.
- Recognizing that interactions with emergency services, especially law enforcement, can increase harms and trauma, NNPBC supports investment in prevention-based services that do not rely on emergency services and law enforcement as first responders for people experiencing mental health crises. This includes "learning from international models where people in crisis are first met by mental health responders, making strategic investments in community mental health and intervening earlier to prevent crisis escalation" (CAMH, 2020).

Background

Involuntary treatment – once considered a safety net of last resort – has become the primary means of providing psychiatric treatment in BC. Involuntary admissions have risen from "11,937 to 20,008 per year over the last ten years"; yet voluntary admissions have remained virtually unchanged with "17,659 to 17,060 per year over the same ten-year period" (Johnston, 2017, p. 13). While both voluntary and involuntary rates should have increased over time – reflecting population growth, these rates indicate an ever-increasing adversarial approach to engaging people with MHI for psychiatric treatment (Johnston, 2017). Involuntary

¹ Involuntary psychiatric treatment includes but is not limited to non-consensual assessment and administration of medication, use of physical and chemical restraints, use of seclusion rooms.



treatment in the community context has increased dramatically as well. The number of those placed on Extended Leave “has nearly tripled in the eight years that the Ministry of Health has been tracking this data” (p. 24). Rising levels of involuntary admissions and treatment – alongside the use of Extended Leave, should act as a major cause for concern, prompting urgent analysis and review of the MHA and overall approaches to psychiatric treatment in BC.

Challenges related to involuntary treatment legislation are not new. In June 1991, the Ontario Court of Appeal ruled that involuntary psychiatric treatment against patients’ wishes and without the consent of their legally appointed substitute decision-makers clearly infringes on their *Charter* rights. Here in BC, the Office of the Ombudsperson published *Listening: A Review of Riverview Hospital, Public Report No. 33* in 1994. This report recommended a review of and amendments to the *Mental Health Act* provisions governing restraints and seclusion and “deemed consent” to psychiatric treatment. The report found that BC “provides significantly fewer substantive and procedural rights to patients than is the case in several other provinces” and that the legislation “appears, on its face, to be discriminatory and to be a denial of the equal benefit of the law.” This 1994 report recommended that the government establish a provincial Mental Health Advocate and fund a legal aid program to provide all involuntary patients with independent rights advice and legal representation.

Despite these disturbing comparisons and clear recommendations, there has been little meaningful reform in BC. The last substantive amendments to the *Mental Health Act* were made in 1998. At this time, criteria for involuntary admission were expanded and the procedural requirements involved in making involuntary admission decisions were reduced. The amendments did not address restraints and seclusion, deemed consent to psychiatric treatment, or independent rights advice for patients. In August of 1998, the Minister of Health did appoint a provincial Mental Health Advocate for BC to “monitor the performance of the mental health system and make recommendations about services and programs for people with the most serious mental illnesses”. However, following the election of a new government in 2001, the office of the Mental Health Advocate was closed, despite an external audit that recommended the office be retained.

In 2017, nearly 25 years after the *Listening: Public Report*, the Community Legal Assistance Society published *Operating in Darkness: BC’s Mental Health Act Detention System*, which documented widespread human rights violations of involuntary patients. *Operating in Darkness* recommended that the government conduct an independent review of the *Mental Health Act* and fund a legal aid program to provide all involuntary patients with independent rights advice and legal representation. In alignment with NNPBC’s recommendations, the report furthermore highlighted the need for increased oversight and accountability of involuntary treatment processes.

In March 2019, the Office of the Ombudsperson published *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act, Special Report No. 42* which documented systemic failures to comply with the procedural safeguards in the *Mental Health Act* and its regulations. Its recommendations included that the government fund a legal aid program to provide all involuntary patients with independent rights advice. Including ongoing auditing and ensuring compliance with the legislation, also being in alignment with NNPBC’s recommendations for practice.

In July 2020, BC’s NDP government introduced Bill 22, an amendment to the MHA that would allow the involuntary hospitalization of youth under 19 for up to seven days following a drug overdose. Keeping youth against their will for up to seven days after an overdose would put them at greater risk of overdosing and dying upon their release, as per the [Chief Coroner’s statement](#). The Bill was paused, and a snap election was called by the NDP. The Bill will now likely be revisited in the upcoming months.

Clear harm to patients has been well documented across these reports spanning decades. It is difficult to understate the challenges nurses face in providing ethical, equitable, person-centred care when practicing under legislation that has been repeatedly shown to be discriminatory and to contribute to conditions that violate patients’ human rights. As the professional association representing all of BC’s nursing designations, NNPBC must advocate for policies and legislation that protect human rights and promote the health and wellbeing of both patients and nurses.



Recommendations

Recommendations for Practice

Education

The BC Office of the Ombudsperson's *Committed to Change (2019)* report highlighted widespread non-compliance with completion of MHA forms. The report called for increased staff training on the MHA, communication of patients' rights under the MHA, and appropriate completion of all forms. Nurses play a critical role in informing patients of their rights and facilitating access to legal supports, while simultaneously being positioned to identify and report non-adherence with treatment. As such, it is crucial that nurses receive appropriate training on the MHA, including parameters of involuntary treatment, completion of forms, and patients' rights.

One-time training sessions, such as initial post-hire orientations, are insufficient to ensure ongoing compliance with the conditions of involuntary treatment under the MHA. Providing annual education can ensure that nurses are aware of changes to the MHA and are incorporating new legal requirements and evidence on involuntary treatment into their practice. Internal audits similar to those described in the *Committed to Change* report can provide nurses with feedback on MHA compliance and allow for tailoring of education to specific knowledge and practice gaps. While many health authorities have developed online modules to facilitate MHA training, in-person sessions are needed to facilitate dialogue and thorough understanding, allow for interdisciplinary coordination, and identify and address organizational gaps in upholding patients' rights. Education should furthermore improve health care providers' understanding of the cultural and political contexts that shape practice, ongoing challenges for professional responsibility, and move towards safer, more equitable health care services.

Equity-oriented Care

According to the Canadian Mental Health Association (2014), "an equity-based approach recognizes that different actions are required to achieve similar outcomes for different individuals or groups due to the uneven distribution of power, wealth and other resources in society" (p. 7). An orientation in equity seeks to reduce power differentials and address issues at the individual and structural level – such as access to safe and secure housing and poverty reduction and promotes the provision of non-coercive and anti-oppressive care (Karban, 2016).

Since BC's MHA grants extraordinary power to detain and involuntarily treat people, it is important to recognize that the MHA disproportionately impacts people who experience structural inequities. Incorporation of equity-oriented care in nursing practice is therefore integral to providing ethical and just care. Equity-oriented care can be integrated into involuntary psychiatric treatment through the integration of practices grounded in trauma and violence informed care, gender affirming care, culturally safe care and harm reduction (Browne, Varcoe, Ford-Gilboe, & Wathen, 2015).

Indigenous and racialized communities are more likely to experience poverty and are disproportionately affected by involuntary and coercive psychiatric treatment. Equity-oriented care must therefore also be explicitly anti-colonial and anti-racist in its approach and practice. Anti-racism "examines the power imbalances between racialized people and non-racialized/ white people... [, where] imbalances play out in the form of unearned privileges that white people benefit from and racialized people do not" (McIntosh, 1988). In mental health institutions and approaches to involuntary treatment, greater emphasis must be placed on anti-racist and anti-colonial practices "that are comprehensive (human resources – e.g. equity in hiring, clinical work, partnerships, resource allocation, systems support, public policy), transparent and accountable" (Ontario Human Rights Commission, 2004).

Nurses can both have an awareness of how society and health care systems create inequities (Canadian Nurses Association, 2017), and take action in practice to respond to inequities. This can include ensuring that institutional policies and practices are tailored to people who experience structural inequities, responding to underlying conditions that worsen health inequities (such as lack of access to income assistance or housing),



and maintaining unconditional positive regard with a person-centered approach (Reutter & Kushner, 2010; Varcoe, Browne, & Cender, 2015). Interdisciplinary communication and explicit organizational and personal commitments to equity-oriented care are vital to ensuring that health care provision meaningfully addresses inequities in health.

Nurses' Role

Nurses are ideally positioned to advocate for changes to the MHA and broader health systems. As health care providers, nurses can directly assist patients with the navigation of complex and often inaccessible services, policies and legislation (Kolar, 2018). Even when a patient is involuntary, nurses can strive for person-centred care by promoting patients' agency and choice. Nurses can furthermore engage in self-reflection, challenging discriminatory views that may arise in the health care team's decision making, while advocating for more equitable treatment for individuals with MHI in their workplace (Kolar, 2018; Naylor, Das, Ross, Honeyman, Thompson, & Gilbert, 2016).

Change in legislation alone will not solve the problem of rising levels of involuntary treatment; nurses are therefore in an ideal position to call attention to and disrupt the social inequities, harmful value systems and practices impacting people with MHI more broadly, engaging in social justice and advocacy regarding the social determinants of health (Livingston, 2013). Much work needs to be done to achieve more accessible, equitable and prevention-oriented health systems and societies for people experiencing MHI. In order to move this work forward, nurses can play an influential role within collaborative, interprofessional health care teams, ensuring that there is always a constructive and open dialogue with patients, families, stakeholders, politicians and policy makers.

Recommendations for Policy

Community Services and Social Safety Net

Increased reliance on involuntary and coercive psychiatric treatment practices is in part due to a lack of adequate early intervention and prevention-based community services. According to the [Canadian Mental Health Association](#), the lack of suitable community-based, voluntary mental health treatment contributes to the restriction and violation of rights and freedoms via the MHA, as patients may deteriorate while attempting to access scarce services. Publicly funded community mental health services remain scarce and difficult to access due to long waitlists and restrictive entrance criteria (Mental Health Commission of Canada, 2013). Private services – such as psychotherapy – must be paid for by patients or private third-party insurance but remain financially inaccessible for many people (Mental Health Commission of Canada, 2013). The impact of a lack of suitable community services can be seen in data from Canadian emergency rooms: of patients seeking emergency care for mental health and/or addictions from 2017-2018, nearly 10% were so-called frequent users, with more than 4 visits over the year (Paltser et al., 2020), suggesting that their needs are not being met by existing services.

These and related factors make it difficult for individuals in BC to access adequate, timely and consistent mental health support and services on a voluntary basis, with many being left to wait for their mental health to deteriorate before receiving access to care or treatment, leading to avoidable harms (Kolar, 2018). The lack of suitable services and barriers to access existing services are particularly notable for certain populations including but not limited to: homeless youth (Schwan et al., 2017), those living in rural areas (Friesen, 2019), and those belonging to traditionally marginalized groups. Furthermore, the stigma experienced by those experiencing MHI has also been identified as a barrier to accessing appropriate mental health treatment (Knaak et al., 2017).

With this in mind, NNPBC calls for increasing the accessibility and availability of community mental health services. In particular, this should be done with an emphasis on voluntary care, and on care which is preventative as opposed to reactive or crisis-driven, in order to reduce the need to make use of involuntary treatment. Examples of such services include low barrier access to drug and alcohol treatment, increased access to free individual and group counselling services, training and support for rural clinicians in mental



health, Integrated Youth Services, telehealth services, peer support workers, Indigenous-centered supports, and family psychoeducation programs.

This takes place within a larger context of social inequity, which amplifies barriers to accessing care, as well as contributing to worse mental health outcomes more generally. As an example of this context, the 2019 Vancouver Homeless Count found the highest number of unhoused individuals since the start of the survey in 2005 (Homelessness Services Association of BC, BC Non-Profit Housing Association and Urban Matters CCC, 2019). With the goal of shifting towards prevention and harm reduction, NNPBC also calls for a strengthening of social supports and the social safety net in BC including support for Housing First Initiatives, income support, rent supplements, child-care and employment support.

Adequate Resourcing for Psychiatric Care and Treatment

In order to ensure health care systems are able to meet their obligations promised by the MHA to involuntary patients, both community and acute psychiatric settings must be provided the resources to effectively meet their obligations. This includes support for the meaningful development of existing resources with ongoing training and clinical supervision from peers and practice experts to support better practice and better health outcomes for the people of BC.

While there was a 29% increase in mental health admissions in BC from 2005 to 2016 there was no commensurate increase in dedicated psychiatric beds (BC Schizophrenia Society and BC Psychiatric Association, 2019). Thus, beyond making better use of existing services, there needs to be an expansion in funding, including but not limited to beds, across the system. One way this can be achieved is through mental health parity, to bring funding and coverage for mental health conditions in line with need and to ensure that mental health treatment and medical treatment have the same status (CMHA, 2018).

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