

**Submission to the Senate Standing Committee on Social Affairs, Science and Technology
Chair: Senator Kirby**

FOCUS ON DISCRIMINATION, ABUSE AND RIGHTS OF THE MENTALLY ILL.

Introduction

Thank you for the opportunity to address this committee. I am someone who has been hospitalized for mental illness. I consider myself lucky, given my experience in the mental health community, to have been, on balance, helped by the intervention of psychiatrists. I am currently the Coordinator, or executive director, of the Vancouver/Richmond Mental Health Network. I am also past President of the organization. I am currently also a board member of the World Network of Users and Survivors of Psychiatry, a human rights NGO based in Denmark. Still, I have much to learn, so I will keep my contribution brief.

One

On p.6 of volume III of the committee's report the committee asks "...how can a patient/client oriented system ensure an appropriate balance between the rights of individuals and the role of society in caring compassionately for them while protecting itself?"

In all the committee's deliberations around this theme special emphasis should be given to the myth of the violent psychiatric patient. The committee has already admitted the existence of this myth. Is society justified in fearing it will be harmed by people with mental illness? The committee must clearly decide whether fears of the mentally ill are unfounded or not.

When the committee writes of caring compassionately, I must let you know that there is another perspective on mental health care in this province. When such care takes the form of detention and forced treatment with neuroleptic medications, electro-convulsive therapy and physical restraints, it cannot avoid violating the dignity of a significant portion of those it tries to help.

In the course of my work I hear stories of abuse, abuse perceived in the eyes of patients, and I feel the force of their outrage at how they have been treated. If we are to continue to force help on vulnerable people, we need to understand the power psychiatrists and service providers have over the psychiatric patient. It is enormous and has few parallels. Given the human frailty of health care professionals, their vulnerability to error, fatigue and complacency, such enormous power, too often taken for granted and as a result abused, must be curtailed. I have been a service provider in social housing and know how easy it is to do emotional violence to the people we are paid to serve. In light of this I would advise a stricter oversight of practices in psychiatric hospitals, and an easily accessible avenue for redress of grievances against perceived abuse at the hands of psychiatrists, psychiatric nurses and service providers in the mental health field. We are talking about protecting the rights of profoundly disempowered people.

The committee is correct in finding discrimination in the denial of basic civil rights to people diagnosed with a mental illness. (p. 25, Volume III). In the history and membership of my organization and the stories that have come to me, I can only hope such deprivation of rights can be addressed with federal legislation by, for example, implementing an appeal system for mental health tribunals, just as the Canada Assistance Plan, in its time, required provinces to include tribunals and appellate bodies to review the decisions of welfare bureaucrats. But in addition to more stringent oversight of decisions involving deprivation of liberty and forced treatment, there is an urgent need for avenues to redress grievances against maltreatment of Canadian citizens

inside psychiatric facilities. Holding psychiatrists liable for damages to patients is a necessary right that must be extended to patients under the mental health acts of the provinces to better regulate the excellence of treatment we must require of psychiatrists. Another way to ensure excellence of treatment is to grant people diagnosed with mental illness the right to informed consent.

While your report refers to the impairment of decision-making capacity of those suffering from mental illness (p.6, Volume III), which may play a role in the exercise of informed consent, the Canadian Association of Community Living created some fifteen years ago a model of what it called “supported decision-making” that could go some way toward ameliorating the impact of such impairment. This supported decision-making model was quite influential in the writing of the Representation Agreement Act of British Columbia in 2000. Unfortunately, the discrimination the committee so rightly has referred to played a role in excluding people detained under the mental health act of this province from the rights provided by this exemplary legislation. Our organization has just completed a draft position paper on the discrimination against the mentally ill found in the Representation Agreement Act of BC.

Two

Enhancing Access: Regarding “A Mental Health Patients’ Charter of Rights” (p. 9 and 10, Volume III) I find it strange that access to care, which also, in our current mental health system includes the concept of involuntary detention under provincial mental health acts, should highlight access rather than liberty, or security of the person as rights needing protection. What I have been saying points out that the gross imbalance of power between psychiatrist and patient is what such a charter should address. Access is not the issue our organization’s presentation is focussing on. Rights, discrimination, these are our concerns.

Three

On p. 52, Volume III, the committee asks whether governments should develop detailed goals, objectives and standards for mental health, mental illness and addiction. In the field of mental health I feel this is neither desirable nor possible, without doing damage to the freedom of individuals. Psychiatric medicine has already created a huge catalogue of behaviours it seeks to pathologize. In our efforts to heal, we have labelled nearly every behaviour under the sun and within the reach of medicine. No, we do not need national mental health standards, medically speaking. In terms of treatment, yes, there should be standards, and more stringent ones than those that already exist. I have already touched on these.

Conclusion

It is all about human dignity. Without a sense of dignity, human life is a nightmare that all the drug therapy in the world cannot relieve. On behalf of the Vancouver/Richmond Mental Health Network I propose that the committee’s final report include the recommendation that the autonomy of the individual in receipt of mental health care, or of the individual prior to receiving any mental health care at all be protected, promoted, and established as deeply as possible.

Submitted by Ron Carten
Coordinator
The Vancouver/Richmond Mental Health Network

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