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Persistent myth about the Mental Health Act

It was an extreme case of hoarding, in a home in Chilliwack – mountains of debris up to seven feet high, a basement flooded by a burst hot-water tank, mould infecting the air, and a problem with rats. It was also quite clear that mental illness was at the root of the situation. The hoarder, now 56 years old, had been seeing a psychiatrist since he was a child, and was subject to other compulsive behaviour, like wiping his fingertips with tissues and then folding and stacking them in piles.

Also living in the house was the man's 90-year-old mother.

The Chilliwack Fire Department's fire prevention officer had been trying without success to get something done, first with counselling and cajoling, then with calls to a variety of public and private agencies, doctors, churches and civic groups, and a call to the Ministry of Seniors.

He also called Fraser Health to explore the possibility of involuntarily admitting the person to hospital where his illness might be dealt with.

Fraser Health replied the couple was capable of living on their own.

The director of Chilliwack Mental Health Services subsequently told the *Chilliwack Times*, in a story on the case in early April, that the person would have to come to hospital on his own – that people can only be committed if they are shown to pose a danger to themselves or others.

One could argue that the man's obsessive behaviour did constitute a danger to himself and others. The place was a fire trap, which is why the fire department was involved. Fire traps are dangers.

"Dangerousness" not required for admission

What caught our particular attention, though, wasn't the hoarding or whether it represented a danger (although common sense suggests it did), but the statement by the Fraser Health official that dangerousness was needed for involuntary admission to begin with.

The official just got it wrong, and misled the fire prevention officer and the Chilliwack public in the process.

Involuntary admission under the B.C. Mental Health Act requires that the person has a mental disorder and hospitalization is needed "to prevent the person's substantial mental or physical deterioration or for the protection of the person or the protection of others."

Dangerousness is not required or even specifically mentioned. A person who is obviously ill and deteriorating can be hospitalized.

The "protection" criterion might also apply in this case. "Protection" in the Mental Health Act has been interpreted by the courts, in a landmark B.C. Supreme Court decision in 1993, to go beyond physical dangerousness, say the possibility of suicide.

The criterion could conceivably apply, then, to protection from the risk of fire, where the person is so disordered they are unable to appreciate the risk or properly protect themselves and others from it.

Mistaken approach can lead to tragedy

More troubling, because of its general significance, is what the Chilliwack mental health director's error says about the culture of mental health services in Fraser Health as a whole. It's hard to imagine the area director of those services making such a fundamental mistake if his misunderstanding of the Mental Health Act were not generally shared in the health authority. We know, too, that correcting the mistake, although necessary, only goes so far: Pointing to what the Act actually says doesn't, in itself, change attitudes and practices which are usually deeply rooted.

This is what is particularly disturbing. The consequences at large of requiring dangerousness in order to involuntarily admit someone to hospital are grim for the acutely ill, not least because the switch from not seeming to be dangerous to doing something tragic can happen quickly, and by that time it's often too late.

The mistaken approach is particularly discouraging in the light of a prior, gut-wrenching tragedy that occurred in Fraser Health's territory not that long ago, the Ross Allan suicide case in 2008, where an inquest brought forward a record 43 recommendations. The lead recommendation, at the very top of the list, was to ensure physicians – and, by extension, one would think, others involved – understood clearly the provisions for involuntary admission.

Fraser Health should have learned by now.

Something needs to be done.

Random stabbing raises several issues

Another random stabbing in Vancouver, this one at a 7-Eleven at Denman and Comox Streets, underscores again how important it is that mental illness be adequately taken into account when the wheels of justice turn, and how equally important it is that if psychotic illness is at the root of a violent assault, the court consider a finding of not criminally responsible on account of a mental disorder (NCRMD).

The case involves a 39-year-old Vancouver man, Jorden Lee Degroot, who stabbed a 30-year-old woman he didn't know multiple times until he was pulled away by customers and staff inside the store. The woman fortunately survived.

What bears on the case is that in 2008 Degroot was sentenced to five years in jail, less one year for prior custody, for aggravated assault after another incident, where he viciously beat a man with a club, apparently fashioned from a tree branch. The

original charge was attempted murder and assault with a weapon. We cannot say for sure that Degroot was mentally ill at the time, but all indications point to it. The presiding judge referred to "mental health issues" and to Degroot, who had a master's degree and previous employment, having "been in some sort of downward spiral since about 2004." Nor did Degroot know the victim of the assault or have any relationship to him. "There is really no explanation for [the assault]," the judge commented.

One other important detail, however: There was no psychiatric assessment, which raises a major question in itself: Why, if he was unstable, was no psychiatric assessment ordered?

The upshot was that where he might have been found NCRMD and assigned to the Forensic Hospital, where treating illness is what the facility does and discharge doesn't happen until stability is achieved, he ended up in an ordinary prison where psychiatric treatment is problematic and discharge occurs automatically at the end of a given sentence.

So there he was, out of prison, apparently unstable again, and stabbing a woman he didn't know. By good fortune, she wasn't fatally hurt. Degroot, in a different way, was a victim, too. Somewhere along the line, in the 2008 trial and subsequently, he should have been given better help. Or as the judge in the 2008 case put it, "It is a very sad thing to see a young man like Mr. Degroot, with all his potential, in this very terrible situation."

We've attempted to find out exactly what help was in fact given to Degroot in prison – whether he did receive treatment, what was its nature, and what follow-up provisions were made to help him with his difficulties when he was discharged. As of press time, unfortunately, we don't have those details.

The Degroot case raises another issue. The federal government has proposed legislation to make discharge of those found NCRMD more difficult in cases of violent crimes. The proposed legislation has been widely criticized. It treats those who are ill as ordinary criminals, not acknowledging how paranoid psychosis, for example, or command hallucinations (voices giving instructions), can lead even the most gentle of people to commit homicide, and how treatment and follow-up can return that person safely to society.

It doesn't recognize, either, that the current system, where Review Boards decide on discharge, works well, with public safety already a primary concern and with some people, because of continuing instability, kept in forensic hospital, a secure facility, longer than they would have been in prison.

This leads to another criticism of the proposed legislation: that if discharge from forensic has inappropriate difficulties standing in its way, defence lawyers would be more inclined to advise a guilty plea, knowing that when the prison sentence ends, the person will be assured of leaving, rather than being subject, perhaps, to a longer stay in forensic if they were found NCRMD. Somebody who is severely ill, in this scenario, will likely still be ill when they get out of prison and could be a greater danger to the public, not to mention their suffering the severe mental disorder all this time and being vulnerable to abuse in prison on top of that.

We don't know exactly how ill Degroot was or what the diagnosis might have been. The case, though, reminds us that for someone with a serious mental disorder, prison isn't the answer, and that forensic psychiatric facilities have been created for just such instances, to get the person well and, by doing so, to protect society at the same time.

Misuse of language distorts reality

As the *Bulletin* has pointed out before, euphemisms for mental illness ("mental health issues" being the most common) aren't just a matter of prettification of language, they blunt appreciation of what is actually involved and what needs to be done to help, hurting the mentally ill in the process.

The most glaring examples, ironically, may be cases of fundraising for psychiatric facilities, where dressing things up to be donor-friendly appears to have become the rule, regardless of its implications. Our favorite example: the package produced by the Lions Gate Hospital Foundation to raise money for a new psychiatric acute-care facility. It included stories on bipolar disorder and depression but not on schizophrenia, although schizophrenia is the most disabling of the serious mental illnesses and is the largest user of psychiatric beds which, after all, was what the fundraising campaign was supposed to be about.

The VGH-UBC Hospital Foundation, now trying to make up for a shortfall in the financing of a new mental health centre of their own, is proving not to be immune.

In a full-page newspaper display ad in March promoting the centre, the hospitals' director of mental health and addiction services is quoted as saying, "Not only is it time to talk more openly about mental health, I feel it's time to be proud that we're finding ways to address and overcome it."

Overcoming mental health? Something to be proud of?

It's just a little absurd and ridiculous, but it's there in black and white in a big-city newspaper, asking to be laughed at. We know, however, how this absurdity happened. If the director had referred, in a matter-of-fact and intellectually honest way, to "mental illness," which is what she was really talking about, her statement would have made sense.

It was those devil euphemisms again.

The distortions of prettification can also play havoc with clinical reality. The same VGH-UBC ad, both in the text and in a "Mental Health Facts" sidebar, tells us that "two in three people do not seek help due to fear of judgment and rejection."

True, there will be some people who don't come in for treatment because of stigma, especially if their illness isn't severe and they can at least get by without help. For the seriously mentally ill, however, which is what a psychiatric facility should be focussed on, the most likely reason people don't come in for treatment is lack of insight into their illness, a clinical condition known as "anosognosia." They literally don't understand they are ill.

This is a "mental health fact" which preoccupies most of the family members who come to the Family Support Centre for help, and which lies at the heart of most cases of severe deterioration and often tragedy, yet it's invisible in the picture drawn up by the foundation.

But at least, in a list of illnesses in another sidebar in the ad, schizophrenia and bipolar disorder were included.