

**INVOLUNTARY AND COERCIVE PSYCHIATRIC TREATMENT: A CRITICAL
DISCOURSE ANALYSIS OF BRITISH COLUMBIA'S MENTAL HEALTH ACT**

by

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Abstract

British Columbia's Mental Health Act (MHA) is a piece of legislation mandating involuntary treatment of people experiencing mental health issues who are unwilling to receive treatment on a voluntary basis. Utilizing Fairclough's Dialectical-Relational Critical Discourse Analysis, this thesis analyzes how the MHA and a companion document, the *Guide to the Mental Health Act*, structures practices of overriding usual requirements for consent to care, and removes self-determination for people deemed in need of involuntary treatment. Findings illustrate how the Act and Guide are constructed within socio-historic discourses of biomedicalism, psychiatry, ableism, colonization, marginalization, and neoliberal orientations of governments. These discourses delineate a boundary between 'normal' or acceptable behaviour and 'abnormal' or unacceptable behaviour deemed in need of correction through psychiatric treatment. The Act and Guide constitute involuntary service-users as patients with "mental disorders" who are too vulnerable or dangerous to care for themselves and therefore in need of protection, from themselves and others. These texts align "mental disorders" with incompetence and incapacity justifying the need for protection. Involuntary and coercive treatment practices authorized by the Act are implemented by nurses, physicians and police officers. The manner in which the Act and Guide constructs patients and protection highlights how discourse operates to produce and maintain dominant social relationships beyond the clinical setting. Thus, the discourses of the Act can be seen as produced within the project of governing and as being central to the maintenance of the social order. Although the MHA's stated intentions are to reduce harm and provide care for people experiencing mental health issues, this analysis illustrates how discourses employed by these texts participate in the violation of safety and consent of the people it intends to serve - commonly disadvantaging those already experiencing

social and economic marginalization. Current health care practices and structures that rely on harmful narratives and discourses based on deficit, vulnerability, dangerousness, and incapacity can be countered by employing discourses of equity. Nurses are ideally positioned to challenge discourses and practices that compromise people with mental health issues' human rights, entrenching social inequity.

Lay Summary

British Columbia's Mental Health Act (MHA) is legislation that authorizes treatment for people with mental health issues who are unwilling to receive voluntary treatment. This study analyzes the MHA and *Guide to the Mental Health Act* to better understand how language is used to facilitate the removal of personal rights and freedoms of service-users. Study findings demonstrate how these texts constitute service-users as patients who are unable to make informed decisions or engage in consent due to having a "mental disorder". This constitution paves the way for their need for protection by healthcare practitioners and police through involuntary psychiatric treatment. This analysis traced the history of the language in these texts to show they are influenced by ideas regarding mental health led by medicine and psychiatry, ideas and practices that are part of social and political projects - such as colonization and discrimination. Study findings illustrate that the use of alternative language based on shared decision making and promotion of consent should be incorporated in these texts to promote service-user rights and safety.

Preface

This thesis is my original, unpublished work, completed in collaboration with my supervisory committee. The discourse analysis portion of this thesis was completed by myself alongside the input of and guidance from my primary supervisor, Dr. Colleen Varcoe and Supervisor Committee Members, Dr. Helen Brown and Dr. Rochelle Einboden. The writing of the thesis was completed in collaboration with all supervisory committee members: Dr. Colleen Varcoe, Dr. Rochelle Einboden and Dr. Helen Brown.

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Chapter 1: Introduction and Background

Introduction

British Columbia's (BC) Mental Health Act (MHA) is a piece of legislation that directs practice and care for people experiencing mental health issues (MHIs). While the MHA's stated intentions are to reduce harm and provide mental health treatment, the legislation has been extensively criticized by service-users, families and advocates alike for issues concerning consent, involuntary treatment, and decision making authority (Johnston, 2017). Under BC's MHA, healthcare practitioners are not obliged to obtain consent, nor is an assessment of service-user capacity to consent completed (Ministry of Health, 2005; Groves, 2011). BC remains the only jurisdiction in Canada that utilizes a 'deemed consent' model – which assumes consent on behalf and in the best interest of the service-user. Through involuntary treatment, seclusion rooms, physical and chemical restraints, locked units, and covert medication administration are often used to elicit compliance to psychiatric treatment (Roberts, 2005). Although numerous ethical and practice concerns have been brought forward, there remains little understanding and awareness regarding how discourses employed by the MHA incite power relations in abusive ways that maintain social inequity for people with MHIs. In this study, I investigated the manner in which discourses employed by the MHA position service-users and investigated the interests served by the MHA as it is currently constructed. I also explored the implications in maintaining this current social order for mental health service-users and nursing practice in BC.

Experiences in Mental Health Practice

I am a psychiatric nurse who has worked in the area of mental health and substance use for five years in both in-patient and community settings. My interest in mental health and substance use initially began while I was volunteering with women and youth experiencing homelessness

and studying Sociology within my undergraduate program. I was concerned by structural issues of stigma, discrimination and ‘othering’ experienced by people with mental health and substance use issues, including how and why such patterns continue to be reproduced within institutions and social systems. I pursued psychiatric nursing in my undergrad in hopes of answering these questions, seeking to learn how to provide ethical care and evidence-based treatment.

In nursing school, ethical principles of autonomy, non-maleficence, beneficence, and social justice were the foundation upon which nursing practice was taught. The program was essential as preparation for mental health nursing practice; we explored the complexities of mental health and substance use, their origins, diagnostic processes, and various forms of treatment available. However, upon beginning my student nurse placements I experienced dissonance between the ethical principles meant to guide my practice and that of direct nursing care. My initial memory of experiencing moral distress as a nursing student arose in seeing a person being physically escorted by four security personnel to a seclusion room, stripped of personal clothing, dressed in a hospital gown, then forcibly injected with neuroleptic and anxiolytic medications for sedation by a nurse. The person was clearly distressed and confused, asking for clarification in relation to why this was occurring, receiving no responses from the nurse or security personnel.

Although I was taught such practices were only engaged when deemed necessary (such as for the protection of self and others) - and was furthermore unaware of the specific context regarding why this person was being secluded, I recall asking my instructor about the ethics related to such practices and how nurses come to normalize these practices as routine. Responses consistently drew on a discourse of safety and risk in conformity with, “It’s for the patient’s safety, and if it’s for safety, it’s the nurse’s responsibility to do whatever it takes”. This response was utterly dissatisfying and only bred further questioning, such as: What is safety? Whose

safety? Who decides what is safe? How and by whom is it decided that seclusion and other coercive treatment practices are an appropriate response? Through all of my psychiatric placements I consistently felt in direct conflict with the coercive practices taking place used to promote involuntary treatment and ‘compliance’. When questioning or signifying apprehensiveness about engaging in such practices that were expected of me as a nurse, I was labelled as disruptive by instructors and peers. I was furthermore refused requested psychiatric clinical placements and informed that priority placements should be for students who actually “want to be a psychiatric nurse”.

Through practice in community and in-patient settings I witnessed both ethical and abusive practices in relation to people receiving involuntary treatment. I witnessed nurses ensuring that service-users were consistently aware of their rights, advocating for appropriate review of their Extended Leave¹, and challenging whether continued certification was in fact necessary. I simultaneously witnessed nurses relying on harmful stereotypes to justify involuntary and coercive treatment practices, violating service-users’ personal freedom and integrity, autonomy and choice. Time and time again I witnessed the use of coercive practices such as threats of injecting medication, recalling to hospital, the use of seclusion and/or restraints to enforce medication and behavioural compliance. I often found the use of (and at times overreliance on) such practices stemmed from assumptions of incapacity, inadequate insight, poor judgment, ‘non-compliance’ and potential or expressed violence by the service-user, alongside an identified lack of time and/or resources experienced by nursing staff.

¹ Extended Leave is a process by which a person admitted involuntarily is released into the community with conditions necessitating adherence to treatment – otherwise recall to hospital will occur.

As a mental health nurse, I was obligated to enforce involuntary and coercive treatment practices that supported the care plan – often developed without input of the service-user. While I understood that involuntary treatment was necessary to prevent further deterioration or harm for some service-users, I could not help but see how structural issues (such as poverty, homelessness, discrimination, lack of appropriate services or access to safe and secure housing) exacerbated service-users’ intersecting health, mental health and substance use issues; in many cases I felt that the MHA was a reactionary measure used to deal with systemic shortfalls on an individual basis. Rather than engaging with or helping address factors contributing to patterns of mental distress and readmission, it became evident to me that the MHA was reinforcing a pattern of mental health intervention that was both ineffective, harmful and nonconsensual.

For example, in the community I witnessed people experiencing substance-induced psychosis certified under the MHA, taken to the emergency department, administered long acting antipsychotic medication via injection (with effects lasting up to a month’s time), and upon the substances clearing (usually between 8 to 48 hours) discharged into the community without connection to additional supports, services or housing. In hopes of reducing admissions, some of such service-users who were deemed “familiar faces” (frequently accessing the emergency department) were placed on Extended Leave allowing for involuntary psychiatric treatment and behavioural regulation to extend into the community setting. Such experiences led me to wonder how the MHA influences how we, as nurses, treat, relate to, justify and normalize certain forms of engagement with service-users experiencing mental health and/or substance use issues.

In my psychiatric nursing program, I was taught that service-user autonomy and choice were central to ethical care and treatment. Critical thinking and advocacy were further deemed integral to the promotion and maintenance of service-user rights. As I voiced my concerns

regarding the dissonance between nursing theory and coercive psychiatric treatment practices in the workplace, I was often met with dismissal from managers and colleagues alike. There were, however, nurses and social workers who were also able to validate these concerns, discussing their attempts in actively resisting and mitigating the harms of involuntary or coercive treatment practices. My practice as a mental health nurse was difficult to reconcile with my personal and professional ethics; I was concerned with how practices intended to keep service-users safe violated their safety.

I decided to pursue graduate school in hopes of creating space to critically engage with my concerns involving involuntary and coercive psychiatric treatment practices. Through the duration of the program I primarily focused on structural violence, mental health, health policy analysis and Critical Discourse Analysis. In the Ethics and Politics of Nursing course, I completed a preliminary review of *Form 5 – Consent for Treatment (Involuntary Patient)* of the MHA (1996). I found that through this form, the MHA does not obligate healthcare practitioners to obtain consent for involuntary treatment, nor is there an assessment of a service-user's capacity to consent. In so doing, Form 5 violates mental health service-user rights of personal liberty and equality. Assessing and comparing provinces' MHAs² exposed how unreasonably behind BC is in protecting and preserving the basic human rights (such as consent, liberty, security, equal treatment, and against cruel and unusual punishment) of involuntary mental health service-users. This initial inquiry spurred my interest in a deeper critical analysis of how BC's MHA maintains these problematic oversights. Further, I became interested in how and why are such oversights maintained. And, the important question of who do these oversights serve?

² Unlike BC, Ontario's MHA has included mandatory capacity assessments, consent to treatment and secondary decision makers (Schizophrenia Society of Ontario, 2013).

I was encouraged to pursue this thesis by the formation of the Ministry of Mental Health and Addiction³ (Government of British Columbia, 2017). This new ministry is seeking to alleviate disparities in mental health and substance use treatment, and will likely review the MHA in the near future due to the multitude of concerns voiced by service-users, their families and advocates (Government of British Columbia, 2017). I felt it was an ideal time to engage in this study to increase awareness of inequitable aspects of mental health care, while potentially helping to inform the upcoming transformation of the MHA - including health policies and procedural documents involving mental health service-users affected by the MHA. I believe that challenging harmful discourses will ultimately shift the ways in which people with MHIs are portrayed in mental health legislation, health policy and practice documents, while achieving improvements in social stigma and direct care practices.

Discourse and Mental Health Legislation

Discourse in Mental Health

Discourses not only construct our understandings of what constitutes a MHI, but also the frameworks for addressing them. While definitions of discourse vary, for the purpose of this study discourses are understood as "... semiotic⁴ ways of construing aspects of the world (physical, social or mental) which can generally be identified with different positions or perspectives of different groups of social actors" (Fairclough, 2009, p. 232). Discourses function to constitute literary bodies in hierarchical relations to each other in accordance to dominant power relations. Thus, discourses within policies and legislation maintain power to shape,

³ In 2017, upon change in government the Ministry of Mental Health and Addiction was created. The new Ministry's mandate is to "improve the access and quality of mental health and addictions services for all British Columbians, as well as develop an immediate response to the opioid public health emergency" (Government of British Columbia, 2017, para. 1).

⁴ Semiotics is defined as the study of signs and symbols, including their application and/or interpretation.

influence, and constitute equitable treatment. For example, the *Canadian Human Rights Act* (1985) is a statute which promotes equal opportunity for people, prohibiting discrimination on grounds based on “race, national or ethnic origin, colour, religion, age, sex, sexual orientation, gender identity or expression, marital status, family status, genetic characteristics, [and] disability” (s. 3-5). However, discourses also play a role in legitimizing and formalizing inequitable treatment, often disadvantaging those already experiencing social and economic marginalization. For people with MHIs specifically, discourses are used in everyday language to exacerbate or reduce the varying degrees of rejection, exclusion, and devaluation experienced through “policies and practices of most institutional systems”, including employment, housing, social welfare, and health care (Law Commission of Ontario [LCO], 2017; Livingston, 2013, p. 12). It is therefore important to analyze how discourse is utilized in the health care context to maintain or ameliorate social systems of degradation and inequity for people experiencing MHIs.

Mental Health Legislation

A key piece of legislation directing mental health treatment in BC is the MHA. The MHA directs the practice and care for people experiencing MHIs. The MHA was implemented in 1964 for healthcare practitioners during the process of deinstitutionalization⁵ with the intention of facilitating treatment within the community context (Yearwood-Lee, 2008). According to the Ministry of Health (2005), the primary purpose of the MHA is to ensure the supervision, protection and care of people experiencing MHIs through the provision of “authority, criteria and procedures for involuntary admission and treatment” (p. 1). The MHA is deployed by physicians in concert with nurses and police to suspend the rights and freedoms of people with MHIs

⁵ Deinstitutionalization refers to the process of transitioning people with MHIs from institutional care settings to community based treatment. Deinstitutionalization began in the late 1960’s and 1970’s across the Western world (Dyck, 2011).

deemed in need of involuntary treatment. The Ministry of Health (2005) states that protections are embedded within the MHA allowing for the least restrictive provision of care necessary.

According to Ministry of Health (2005), these safeguards assist in maintaining and promoting the rights of people admitted under the MHA through rights notification, repeating certificate renewals, access to review panel hearings, court review, including the option for a second medical opinion. The Ministry of Health (2005) argues that without involuntary treatment authorized by the MHA, individuals with MHIs would needlessly suffer, “causing significant disruption and harm to their lives and the lives of others” (p. 1). Involuntary treatment is deemed essential for circumstances involving people with MHIs experiencing impaired insight and an unwillingness to accept voluntary treatment to mitigate substantial risk of deterioration, as well as harm to self or others. The Ministry of Health (2005) created the *Guide to the Mental Health Act* (Guide to the MHA) to help translate the MHA for service-users, their families and healthcare practitioners.

Although the intention of involuntary treatment is to reduce harm and provide care for people experiencing MHIs, the ethics of this practice are under scrutiny in relation to consent, involuntary treatment, and decision making authority (Johnston, 2017). BC is the only jurisdiction in Canada that utilizes a ‘deemed consent’ model. Deemed consent assumes consent on behalf and in the best interest of service-users. BC’s MHA lacks the assessment of a person’s capacity to provide consent and the director’s⁶, physician’s or nurses obligation to obtain consent from the service-user for involuntary treatment (Groves, 2011). The MHA is underpinned by the assumption that people with MHIs who fulfill the criteria outlined in *Form 4: Medical*

⁶ Directors are identified in the MHA as persons who are appointed by a health authority and “responsible for the operation of a designated facility” – usually being a physician or nurse (Ministry of Health, 2005, p. 2). A designated facility is a hospital that has been approved for the purpose of involuntary psychiatric treatment.

*Certificate (Involuntary Admission)*⁷ are incapable of providing consent or making informed decisions. Therefore, through involuntary treatment, the service-user is legally assumed to have consented to any form of psychiatric treatment that is deemed appropriate by the treating physician.

Failure to adequately assess for capacity to consent and/or obtain consent may be met with non-cooperation from the service-user due to the removal of autonomy and choice via involuntary psychiatric treatment (Johnston, 2017). Non-cooperation from the service-user is often followed by coercive treatment measures and forced compliance through withholding of personal clothing, the use of seclusion rooms, and the use of chemical and physical restraint (Johnston, 2017). Such practices have been found to produce a counter-therapeutic effect, including “future treatment avoidance; mistrust of the system; decreased future help-seeking behaviour”; longer hospital stays; and trauma (Schizophrenia Society of Ontario, 2013, p. 32).

Without adequately assessing for and/or obtaining consent⁸, involuntary treatment under the MHA violates the right to personal liberty, security and equality for people with MHIs (LCO, 2013). If the service-user is discharged from the hospital on Extended Leave, involuntary treatment measures that breach consent are translated into the community setting; on Extended

⁷ Criteria include, an individual who maintains a MHI that “seriously impairs” their ability to “react appropriately” to their environment and “associate with others”; “requires treatment in or through a designated facility”; and “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 “cannot suitably be admitted as a voluntary patient” (MHA, 1996, s. 22).

⁸ The process of assessing for capacity to consent, including seeking consent from service-users with MHIs to maintain individual liberties is discussed in Chapter 4. Assessment for capacity to consent has been successfully integrated in the Ontario MHA, where the physician determines the service-user’s capacity to consent through a two-part test as well as providing an option for a substitute-decision maker (Canadian Mental Health Association, 2017; Ontario Hospital Association, 2016). Determining capacity to consent to mental health treatment involves: whether the service-user “is able to understand the information relevant to making a decision about the proposed treatment”; and the service-user “is able to appreciate the reasonably foreseeable consequences of their decision” (Ontario Hospital Association, 2016, p. 2-4).

Leave, the service-user must continue to adhere to the assigned treatment plan - regardless of whether it was completed in consultation with the service-user or not, otherwise the person risks readmission to hospital. Service-users, their families, advocates and organizations such as Mental Patients Association (MPA)⁹, have been calling for an in depth review of the MHA for over 20 years due to concerns related to the ‘deemed consent’ model, coercive treatment practices, lack of legal representation and protection of service-user rights (BC Nurses’ Union, 2015; MPA Society, 2012). BC’s MHA is currently facing a Supreme Court challenge for violation of the *Canadian Charter of Rights and Freedoms* (1982) in relation to issues of consent and involuntary treatment (Johnston, 2017).

Johnston (2017) conducted a research project with the goal of investigating and making public “some of the most common and troubling components of the administrative system for mental health detention and involuntary psychiatric treatment in BC” (p. 6). Interviews were conducted with 21 lawyers and legal advocates experienced in “providing legal representation to clients challenging their Mental Health Act detention at review panels” (p. 9). While my analysis and findings draw from the significance of Johnston’s (2017) study, my research expands beyond a focus on administrative system components to critically examine the way structures and practices articulate around involuntary care to incite power relations in abusive and discriminatory ways, maintaining social inequity for people experiencing MHIs. The MHA includes both voluntary and involuntary treatment forms; this study focused on the forms and practices specifically related to involuntary treatment.

⁹ A society was established in 1971 for people who engaged with mental health services (MPA Society, 2012). Under the premise of a democratic-style advocacy and support group, the MPA provided a sense of community and assisted with reintegration of the person into the community. MPA also advocated for further integration of ‘patients’ throughout the mental health treatment process.

According to Johnston (2017), a variety of factors contribute to inadequate protection of service-user rights, such as lack of government oversight and accountability, inadequate legal education of physicians, as well as an overall lack of funding for legal aid and advocacy. The last comprehensive, systemic review of BC’s mental health detention system occurred in 1994, with the last significant amendments to the MHA occurring in 1998¹⁰ (Johnston, 2017). A provincial Mental Health Advocate was established in 1998, however this role was eliminated in 2001 (Johnston, 2017). Furthermore, while BC’s Ministry of Health¹¹ is responsible for implementing and enforcing the MHA, it “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 length of detention periods” (p. 18-19). The Mental Health Review Board, an independent administrative tribunal responsible for completing review panel hearings, also does not publish any reports, policies, or guidelines (2017). Due to this lack of accountability and oversight concerning the MHA, BC has been “considered the most regressive jurisdiction in Canada for mental health detention and involuntary psychiatric treatment” (p. 6).

Involuntary admission has become one of the primary means of providing acute mental health care 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

¹⁰ Minor amendments to the MHA were enacted in 2018 - as outlined in Chapter 4.

¹¹ In 2017, upon change in government the Ministry of Mental Health and Addiction was created. The new Ministry’s mandate is to “improve the access and quality of mental health and addictions services for all British Columbians, as well as develop an immediate response to the opioid public health emergency” (Government of British Columbia, 2017, para. 1). The Ministry of Mental Health and Addiction is actively seeking to alleviate disparities in treatment and will likely review the MHA due to the voiced concerns of service-users, their families and advocates.

and involuntary rates should have increased over time - reflecting population growth, these rates indicate an ever-increasing adversarial approach to engaging people with MHIs for psychiatric treatment (2017). Involuntary 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”¹² (p. 24). Rising levels of involuntary admissions and treatment, alongside the use of Extended Leave in the BC context calls for urgent analysis and review of the MHA and overall approaches to mental health treatment.

The MHA operates in hospitals and community settings through its implementation by healthcare practitioners such as physicians, nurses, social workers and by police officers. Since nurses maintain the majority of direct care and contact with people involuntarily detained under the MHA, they are in a unique position to safeguard personal rights through promotion of self-determination and autonomy, while mitigating use of coercion. Resistance to avoid coercive treatment practices surrounding involuntary treatment can be supported by nurses’ awareness of the discriminatory discourses and assumptions embedded within the MHA, including the Guide to the MHA. Such awareness could further support nurses’ contributions to the upcoming revisions of the MHA.

The current response to MHIs is detrimental to the agency and wellbeing of many people in BC; however, it has remained unclear how discourses employed by the MHA sustain abusive and discriminatory power relations, maintaining inequity for people with MHIs. While research has addressed problematic aspects of mental health legislation in BC, a discourse analysis of BC’s MHA, including the Guide to the MHA, has not yet been conducted. A critical discourse

¹² Data for rates of involuntary treatment and Extended Leave were obtained by Johnston (2017) via “Freedom of Information request submitted to the Ministry of Health” (p. 23).

analysis of the MHA, alongside the Guide to the MHA, highlighted how discourse operates to position service-users and the implications of this positioning. Critically analyzing discourses embedded within the MHA and Guide to the MHA made visible the power relations embodied within the texts, and made explicit what and whose interests are served (Ministry of Health, 2005). Through discourse analysis, this study provided insight into how specific discourses effect service-users, mental health treatment and nursing practice in BC. This study provided the basis for challenging and offering alternatives to the current discourses embedded within the MHA and Guide to the MHA. This study will inform mental health policy reform by providing discursive alternatives to those currently enacted through the MHA with the goal of more equitable approaches to mental health practice and treatment.

Research Questions

This research examines the following research questions:

1. How does the Mental Health Act construct and position involuntary mental health service-users?
2. What and whose interests are served by the Mental Health Act?
3. What are the implications of utilizing these constructions and positions for people with mental health issues and for nursing practice in British Columbia?

Thesis Outline

This chapter has provided context for the study by articulating problems in relation to mental health practice providing a background regarding mental health legislation, explaining the intersections between discourse and mental health legislation, reasons for undertaking the study, and presenting the research questions. Chapter two describes and justifies the theoretical framework and methodological approach utilized for the study, the methodological tool used to

operationalize the study, alongside ethical considerations and limitations of the study. Chapter three provides a critical overview of the socio-historic context of mental health, psychiatry and BC's MHA. Chapter four analyzes and discusses discourses within the MHA and the Guide to the MHA. The discourse of protection figures centrally, and how protection is enacted and by who. The construction and positioning of service-users is also analyzed. Chapter five explores implications of the specific construction of protection utilized by the Act and Guide for service-users and nursing practice. Chapter six concludes the study providing recommendations and conclusions.

It is important to note that it is not my intention to demonize or impugn all forms of involuntary mental health treatment or psychiatry. I want to acknowledge that involuntary mental health treatment has saved lives and continues to provide treatment for many who are deemed in need and would otherwise not receive treatment. Rather, through critical discourse analysis the purpose of this study is to disclose the underlying power dynamics and inequities formalized by the MHA, including how the MHA relies heavily upon socio-historically informed discourses to maintain and legitimize coercive treatment practices. I want to highlight, “even as social narratives around mental health shift to accommodate the rejection of harmful attitudes and stigma, the practices and power dynamics associated with historical views and institutions remain entrenched” and will continue being utilized (Feuston & Piper, 2018, para. 1).

Chapter 2: Theoretical Framework and Methodology

Critical Social Theory and Critical Discourse Analysis

Following a biomedical tradition, discursive practices in relation to MHIs delineate normality from abnormality, and interpret thoughts, feelings and behaviours through provision of mental health diagnoses. These discursive practices “are the means by which mental health professionals are able to structure and apprehend the phenomena that confronts them in everyday practice” such as the use of surveillance and coercive measures used to elicit compliance to psychiatric treatment (Roberts, 2005, p. 39). Strategies for surveillance are enacted primarily by nurses through direct service-user “observations, record keeping, ... ongoing assessment, planning, implementation and evaluation of ‘nursing interventions’, individual and group therapy, ongoing risk assessments, [and] regular ward reviews” (Roberts, 2005). Explicit exercising of power within psychiatry is also found through the practice of involuntary treatment.

Within the social world, discourses operate to construct and influence identity, relationships, and systems of knowledge (Fairclough, 1992). Critical Social Theory (CST) provides a theoretical foundation that supports the critique of power relations and domination through the critical analysis of discourse (Van Dijk, 2001). A CST informed approach to discourse sees communication (spoken, written and/or visual) as actively constructing, reproducing, reflecting, and transforming society through ideology and power relations, while also taking into consideration social and historical context (Fairclough, Mulderrig, & Wodak, 2011). Critical Discourse Analysis (CDA) is highly influenced by CST and is defined as a theory that analyzes and exposes “structural relationships of dominance, discrimination, power and control as manifested in language” (Wodak & Meyer, 2001, p. 2). In other words, CST assists CDA to explore and expose how the structural context of oppressions, dominance, and inequality

are enacted and reproduced through textual features within a social and political context (Evans-Agnew, Johnson, Liu, & Boutain, 2016).

This study utilized a CST perspective which seeks to confront social and ideological structures that maintain inequitable power relations (Habeas, 1964). CST can contribute to the nursing profession's efforts to both resist and shift dominant understandings of MHIs, including the process of and reliance on coercive psychiatric treatment practices. Through CDA it is possible to see how legislation and health policy encompass more than prescriptive texts; rather, such texts can be analyzed for how they sustain and reflect values and discourses legitimizing relations of power (Fiske & Browne, 2008). CST in combination with CDA can help surface taken for granted discourses of psychiatry and biomedicalism that dominate mental health care systems, and the social and ideological structures that incite inequitable power relations for people experiencing MHIs. Informed by CST, this CDA will contribute to mental health policy and practice reform by seeking alternatives that maximize self-determination, autonomy and dignity for people experiencing involuntary psychiatric treatment, and for people with MHIs more broadly.

Methods and Data Analysis

Fairclough's (2009) Dialectical-Relational CDA frames the methodology. Dialectical-Relational CDA sees relations among varying elements (such as power, values, and beliefs) as dialectical, meaning different yet inseparable (Fairclough, 2009). The Dialectical-Relational CDA proposed by Fairclough (2009, p. 167-171) is comprised of four stages. Stage 1 focuses on a social wrong, in its semiotic aspects and is composed of two steps. Step 1 involves the selection of a research topic which relates to or points to a social wrong that can be productively approached in a trans-disciplinary manner with a particular focus on dialectical relations between

semiotic and other ‘moments’. Step 2 involves constructing the objects of research for selected research topics by theorizing them in a trans-disciplinary manner. Stage 2 includes three steps to identify obstacles in addressing the social wrong. Step 1 involves the analysis of dialectical relations between semiosis and other social elements: between orders of discourse and other elements of social practices, between texts and other elements of events. Step 2 involves the selection of texts, and points of focus and categories for their analysis, in the light of and appropriate to the constitution of the object of research. In Step 3, both interdiscursive and linguistic/semiotic analysis of texts are carried out. Stage 3 involves consideration of whether the social order ‘needs’ the social wrong. And finally, Stage 4 involves the identification of possible ways past the obstacles. Although the Dialectical-Relational CDA is outlined in a sequential manner, Fairclough (2013) indicates that CDA is an iterative research process when analyzing discourse. Each of these steps is outlined in relation to the research topic in further detail below.

Stage 1: Focus upon a social wrong, in its semiotic aspects.

The MHA is positioned as an authoritative text for involuntary psychiatric treatment in BC, determining the practice of healthcare practitioners and police towards people experiencing MHIs. The MHA authorizes social actors to remove self-determination and ignore consent from service-users who fulfill predetermined criteria. Debates concerning involuntary treatment typically pertain to issues of deemed consent, personal liberty and use of coercive treatment practices. While other provinces have updated their MHAs to be more closely aligned with *The Charter of Rights and Freedoms* (1982), BC’s MHA continues to lag behind. As aforementioned, the last comprehensive, systemic review of BC’s mental health detention system occurred in 1994, with the most significant amendments to the MHA occurring in 1998 (Johnston, 2017).

In relation to involuntary psychiatric treatment, people who experience structural and social marginalization also experience disproportionate levels of certification under the MHA. For example, people with “developmental, intellectual, neurological, mental health or cognitive disabilities” are more likely to be deemed legally incapable of making informed treatment decisions by physicians and nurses and are therefore more likely to be subject to involuntary treatment (LCO, 2017, p. 35). Older adults are disproportionately affected by cognitive disabilities which increases their likelihood of experiencing involuntary treatment (LCO, 2017). Practice influenced by the MHA further disregards social and structural marginalization that contributes to MHIs, including the impact of wider social contexts such as poverty and discrimination; both older adults and persons with disabilities are more likely to live in poverty and are therefore more likely to experience involuntary treatment (LCO, 2017; Livingston, 2013). Populations disproportionately affected by the MHA also include racialized and Indigenous populations, women, people identifying as LGBTQ2S and/or gender diverse, people with physical disabilities, including people with substance use issues (Dyck, 2011; LCO, 2017; Livingston, 2013; Ontario Human Rights Commission, n.d.; Secker, 1999).

The social wrong pursued by this thesis is the manner in which the MHA removes self-determination and ignores consent of people deemed in need of involuntary treatment, granting unequivocal power to social actors who already occupy dominant social positions, such as physicians, nurses and police. Thus, analysis shows how the MHA allows dominant and discriminatory relations of power to concentrate, and how it participates in deepening social inequity. This social wrong was approached in a trans-disciplinary¹³ manner incorporating

¹³ As per Fairclough (2009), trans-disciplinary refers to interdisciplinary research that “... sees ‘dialogue’ between ... [disciplines and theories] as a source for the theoretical and methodological development” to address research issues (p. 164).

aspects of critical psychiatry, nursing, sociology and philosophy. The incorporation of critical psychiatry offered the examination of dominant mental health practices, such as the diagnostic process and treatment of MHIs. Nursing and nursing theory provided insight into the dissonance between involuntary and coercive psychiatric treatment formalized by the MHA and that of ethical nursing practice. Sociology provided a structural level analysis of the manner in which the MHA affects or engages with social relationships, power dynamics and institutions. Finally, the discipline of philosophy assisted with the analysis of the construction of reality, identity, and meaning in relation to mental health and MHIs.

Stage 2: Identify obstacles to addressing the social wrong.

Within this stage I explored the obstacles in addressing dominant discourses within the MHA. Obstacles included the social and historical influences towards the conceptualization of MHIs, biomedicalism, medical authority, psychiatry, ableism and the positioning of people with MHIs, alongside the history of colonization and increasing neoliberal orientations of government. I also examined the ways in which mental health and nursing practice are organized, which prevent the social wrong from being addressed. I challenged the ableist justifications for coercive treatment practices used to elicit compliance under the MHA.

Step 1: Analyze dialectical relations between semiosis and other social elements: between orders of discourse and other elements of social practices, between texts and other elements of events.

I examined the complex relationship between socio-historic discourses and their influence on the MHA and the Guide to the MHA, how such discourses position service-users, and the impact such discourses have on nursing practice. I explored how involuntary and coercive treatment specifically operates within mental health practice, facilitated by the MHA. I also drew

upon the *Code of Ethics for Registered Nurses* (Canadian Nursing Association, 2017) to highlight discrepancies and tensions between professional obligations under the MHA and ethical nursing practice.

Step 2: Select texts, and points of focus and categories for their analysis, in the light of and appropriate to the constitution of the object of research.

A textual analysis of selected forms and sections from BC's MHA was undertaken – outlined in Table 1. Sections relating to the selected MHA forms within the *Guide to the Mental Health Act* were also analyzed – pp. 1-54 and pp. 66-94 (Ministry of Health, 2005). These texts were analyzed using Fairclough's (2009) Dialectical–Relational CDA and were selected for analysis due to the significant authority and influence they maintain over mental health practice, formalizing involuntary treatment. The *Guide to the Mental Health Act* was chosen because it is the primary document used to interpret and implement the MHA into practice for healthcare practitioners, service-users and families. The identified MHA forms were specifically chosen because they define the need for involuntary intervention and treatment, individual rights while under apprehension, and the process of obtaining consent for involuntary treatment. This discourse analysis addressed all research questions outlined above, uncovering how structures and practices articulate around involuntary treatment to incite power relations in abusive and discriminatory ways, maintaining inequity for mental health service-users.

Mental Health Act Forms and Sections
<i>Form 4 Medical Certificate (Involuntary Admission)</i>
<i>Form 5 Consent for Treatment (Involuntary Patient)</i>
<i>Form 6 Medical Report on Examination of Involuntary Patient (Renewal Certificate)</i>
<i>Form 13 Notification to Involuntary Patient of Rights Under the Mental Health Act</i>
<i>Form 15 Nomination of Near Relative</i>
<i>Form 17 Notification to Near Relative (Discharge of Involuntary Patient)</i>
<i>Form 20 Leave Authorization</i>
<i>Form 21 Director's Warrant (Apprehension of Patient)</i>
<i>Section 3 BCACP Police Triage Guide</i>
<i>Section 16 Protection from Liability</i>
<i>Section 28 Police Intervention</i>

Table 1: Mental Health Act Forms and Sections

Step 3: Carry out analysis of texts, both interdiscursive analysis¹⁴, and linguistic/semiotic¹⁵ analysis.

A major focus of the analysis related to the discourse of protection. CDA of protection led to further analysis of the MHA, including discourses of biomedicalism, psychiatry, paternalism, neoliberalism, colonialism and ableism. Within this step, I analyzed the selected MHA forms and related sections in the Guide to the MHA (as outlined in the methods and data analysis section)

¹⁴ Interdiscursive analysis refers to “analysis of which genres, discourses and styles are drawn upon, and how they are articulated together” (Fairclough, 2009, p. 170).

¹⁵ Linguistic analysis involves the analysis of written text and language use (Fairclough, 2009).

for discourses of protection, including the roles of healthcare practitioners and police officers in implementing protection (MHA, 1996; Ministry of Health, 2005). I furthermore analyzed how service-users are constructed in these texts. The CDA was completed by analyzing text utilized by the Act and Guide, as well assessing for the underlying meanings and values therein.

Stage 3: Consider whether the social order 'needs' the social wrong.

In this stage I explored how the current social order (involuntary and coercive psychiatry treatment) 'needs' the social wrong (the manner in which the MHA incites dominant and discriminatory relations of power). I analyzed how involuntary and coercive treatment practices are mechanisms used to legitimize and preserve social inequities and dominant power relations – as formalized by the MHA. I also explored how the MHA extends support towards practices of governing human behaviour in contemporary society more broadly.

Stage 4: Identify possible ways past the obstacles.

Through discourse analysis, alternatives are provided to current, seemingly immutable, structures. In this stage I discussed how the current social order - specifically in relation to nursing, can evolve to ensure the safeguarding of personal rights through promotion of self-determination and consent, mitigating the use of coercion. I furthermore explored how nurses maintain the ethical obligation to promote and maintain self-determination and consent for people experiencing MHIs, including the need to create and advocate for more equitable mental health legislation in BC. I discussed ways to dismantle the obstacles by addressing the dominant discourses relied upon to sustain inequitable and discriminatory power relations – aligning BC's MHA with *The Charter of Rights and Freedoms (1982)*. I also explored how discourses of equity and equity-oriented practice are alternatives to current conceptualizations and approaches to mental health practice and treatment.

Ethical Considerations and Limitations

There was no human subject involvement, meaning no participants were interviewed or observed through the course of this research study. Overall research risk is low due to the absence of human involvement. Only publicly available texts were analyzed, therefore application to and approval from UBC's Behavioural Research and Ethics Board was not necessary for the completion of this study.

Due to my exposure to the MHA through nursing practice and education, my analysis is not value-neutral or 'objective'. In utilizing CDA, I take an explicit ideological stance against inequity, discrimination, and abuse of power. This CDA of the MHA is focused on how discourse produces and reproduces inequity and discrimination, which is inherently political. According to CST, this is not deemed a limitation since power relations are inherent in every aspect of society, with no possibility of true objectivity or distancing from these power relations. Rather than being deemed a limitation, CST guides researchers to identify their positions of power, rather than proceeding as if one can be power-neutral or 'objective' during processes of data collection and analysis.

CDA does not provide absolute answers to the problems identified. However, research that integrates CDA has the potential to challenge and assist the transformation of current practices, policies and legislation that may be reinforcing or producing harm and inequity. CDA is highly variable depending on the specific research design and approach, therefore how findings are constructed is open to negotiation and interpretation (Breeze, 2011). Nevertheless, the findings can be utilized in assisting with the discourse analysis process of health policies or practice texts influenced by the MHA within BC and may have relevance to similar texts elsewhere.

Chapter 3: Context of Mental Health and the BC Mental Health Act

Mental Health in Canada – History and Context

Conceptualizations of mental health and MHIs “are thoroughly enmeshed within the history of the culture and the society in which they occur and, therefore, are inextricably bound to the political concerns, norms and values of that culture and society” (Roberts, 2005, p. 37). A brief historical overview of mental health is provided to outline the shifts and trends in psychiatry and socio-cultural understandings of MHIs in Canada. This overview provides context to BC’s MHA and current approaches to mental health treatment.

Early understandings of MHIs in Europe and the Western world were based upon cultural, spiritual and religious beliefs – such as religious punishment, demonic possession or personal failing (Senate Canada, 2004; Shorter, 2008). Up until the 19th century, treatment of people with MHIs was “primarily a family responsibility, and patients who could not be cared for at home were placed in jails and poorhouses under deplorable conditions ... [such as:] overcrowding, poor sanitary conditions, inadequate food and heating, and no intervention or treatment” (Goodman, 2006, para. 5). For example, in BC, people with MHIs were placed in the New Westminster Jail and were kept in barred rooms, often experiencing abuse from jail staff (Foulkes, 1961). At this time, people with MHIs were “thought to be morally unfit and were treated essentially as sinners” (Goodman, 2006, para. 5).

The first asylum¹⁶ in Canada for MHIs opened in 1835 in Saint John, New Brunswick (Goodman, 2006). The first asylum in BC – the Victoria Lunatic Asylum¹⁷, opened in 1872 and

¹⁶ Initially institutions for people labelled with MHIs were termed ‘asylums’. The term asylum is now derogatory slang for mental health institutions and no longer appropriate for use.

¹⁷ This asylum closed in 1878 after only six years of operation due to issues of overcrowding (Chunn & Menzies, 1998). Patients were moved to the Provincial Asylum for the Insane which eventually became known as the Woodlands Institution, Essondale and later as Riverview Hospital.

was located on the Songhees First Nations reserve (Chunn & Menzies, 1998). The intention of institutionalization at this time was to systematically segregate people with MHIs from the general population. Segregation was relied upon as a means to reduce contact between those deemed emotionally and behaviourally ‘deviant’ and general society to reduce risk of potential ‘contamination’ or harm (Farreras, 2018).

People in asylums were typically institutionalized against their will. These institutions had little to no regard for the quality of life for people labelled with MHIs; people in these institutions were commonly shackled, isolated, provided little or no activity and were living in unsanitary conditions (Farreras, 2018). There were also instances of people confined in asylums being exhibited to the public for a fee as a form of entertainment (Farreras, 2018). In the early 1900’s, people with MHIs were likened to animals “who did not have the capacity to reason, could not control themselves, were capable of violence without provocation, did not have the same physical sensitivity to pain or temperature, and could live in miserable conditions without complaint” (Farreras, 2018, para. 10).

In the 19th to 20th century, protests regarding substandard conditions and treatment by patients, their families and advocates, alongside the adoption of a neurobiological understanding of MHIs, stimulated employment of more humanitarian approaches to mental health treatment (Farreras, 2018). This shift in conceptualization and treatment encouraged the removal of shackles, provision of sanitary, well-lit and ventilated rooms, as well as prescriptions for ‘purposeful activity’ (Farreras, 2018). ‘Purposeful activity’ “functioned as an essential component of therapy, allegedly teaching the moral virtues of industriousness, discipline, responsibility and skills” while simultaneously performing most of the cleaning and maintenance

of the asylum¹⁸ (Dyck, 2011, p. 183). Treatment of MHIs at this time was dominated by somatogenic theories, which included “blood-letting, gyrotors, and tranquilizer chairs” (Farreras, 2018, para. 13). The rapid growth of the asylum population quickly presented with issues of overcrowding, substandard treatment, abuse and custodial-like care (Farreras, 2018).

Changes in the treatment of people with MHIs across Canada and the United States were initiated by people such as, Dorothea L. Dix (1802-1887), Clifford W. Beers (1876-1943), Richard M. Bucke (1837-1902), Charles K. Clarke (1857-1924), and Clarence M. Hincks (1885-1964) (Goodman, 2006, para. 6). These individuals helped to establish state hospitals (then deemed “mental institutions”), advocated for more humane treatment, early detection and prevention of MHIs, and condemned the extensive abuse that was taking place within institutions (Goodman, 2006). During the industrialization period, “mental institutions” rapidly expanded in size and number (Brunton, 2004). While initially progressive and well intentioned, these institutions structured staff behaviour to remain impersonal and custodial in nature with very little therapeutic activity or engagement provided for those admitted (Farreras, 2018). Similar to asylums, these institutions also experienced issues of overcrowding, cultivating an organizational environment ripe for the ongoing abuse of people who were admitted.

According to Dyck (2011), the twentieth-century conceptualization of MHIs “involved a different set of ideological and cultural precedents, but contained remnants of some of these earlier influences” (p. 182). The conceptualization of MHIs arising from biological abnormalities

¹⁸ The provincial mental health institution in BC - Riverview Hospital, provided programs teaching horticulture, farming, sewing, and woodworking (Laanela, 2014). The practice of ‘purposeful activity’ increasingly became a point of contention due to the hospital making profits off of the unpaid labor of residence. These programs were reduced and discontinued overtime due to these concerns, alongside changes in treatment approach, cost of maintaining such programs, selling of land to developers and the process of deinstitutionalization – facilitating the integration of individuals back into the community setting as soon as possible.

remained dominant, encouraging biological and somatic remedies such as lobotomies¹⁹, electroconvulsive therapy, reproductive sterilizations, hydrotherapy - among other invasive bodily treatments (Dyck, 2011; Farreras, 2018). Those who were subjugated to these profoundly destructive procedures were often not informed and therefore unaware of the procedure taking place. Forced sterilization occurred at Riverview Hospital between 1940-1968, due to issues of record keeping exact numbers are unknown; a minimum of 200 sterilizations were recorded to have taken place in BC and approximately 3,000 in Ontario (Belshaw, 2016; Dyck, 2011). According to Dyck (2011), “emphasis on one’s value in the workforce continued to frame discourses on categories of ability and disability, as they had during the rise of the asylum” (p. 183). Stigma remained pervasive in the 20th century as well; it was not until the 1950’s that the Canadian Mental Health Association successfully advocated to modify the language used in legislation and public discourse that referred to individuals with MHIs as “lunatics”, “idiots”, and “imbeciles” (Senate Canada, 2004).

In the late 1960’s to 1970’s, deinstitutionalization began to occur across the Western world and Europe (Dyck, 2011). Deinstitutionalization refers to the process of transitioning people from institutional care settings to community based treatment (Yearwood-Lee, 2008). Deinstitutionalization occurred as a result of the disability rights movement’s call for closure of mental health institutions (in relation to the negative consequences of institutionalized care), the development of psychotropic medications and the government’s desire to reduce expenditure (Dyck, 2011). While the goal of deinstitutionalization was to promote reintegration and rehabilitation of people who had been institutionalized in the community setting, inadequate

¹⁹ Restraints, lobotomies, and ECT continued to be heavily, and at times excessively, used in institutions up until the mid-1970s (Farreras, 2018). ECT continues to be utilized in a therapeutic manner today.

resource allocation and continuity of care led to a high frequency of relapse, frequent and regular readmission to hospital, including increased homelessness, reliance on emergency services, criminal behaviour and incarceration²⁰ (Senate Canada, 2004). BC's Riverview Hospital officially closed in 2012, however "the site and its use continues to be a flashpoint for discussions about how best to support people with" severe and persistent MHIs (Morrow, 2017, para. 12). The community model remains the primary approach to mental health treatment across Canada, with specialized psychiatric units in hospitals for brief intervention and treatment of acute MHIs. Recently, there have been calls for re-institutionalization; according to Morrow, Dagg, and Pederson (2008), this reflects ongoing and "historic tensions between providing support and imposing control on people with mental health challenges and it is precisely this tension that is evident" within the MHA (p. 1).

Similar to other North American and European cities, deinstitutionalization also "occurred in a context of dramatic health and social welfare restructuring" (Morrow, Dagg, & Pederson, 2008, p. 3). Beginning in the mid-1990s, BC's healthcare system "had undergone successive waves of decentralization and restructuring - including regionalization", in an attempt to contain costs²¹ (Fleet, Plant, Ness, & Moola, 2013; Morrow, Dagg, & Pederson, 2008, p. 3). Healthcare restructuring lead to a reduction in hospital beds, consolidation of departments and programs, alongside the closure of hospitals – predominantly in rural areas (Aiken, Clarke, & Sloane, 2002; Fleet, Plant, Ness, & Moola, 2013). Restructuring of the social welfare system included freezing

²⁰ The outcomes of deinstitutionalization remain contentious; critics highlight that relying on arguments of inadequate resource allocation as the primary issue of deinstitutionalization ignores structural issues and practices of psychiatry itself. As eloquently stated by McWade (2016), "... it is not psychiatric practices that are deemed to be failed or flawed, but rather the institutions in which psychiatry was practiced" (p. 66).

²¹ The intended outcome of restructuring was to create health care delivery systems that were increasingly standardized, efficient, productive, cost effective and responsive (Anderson, Tang, & Blue, 2007; Weiss, Malone, Merighi, & Benner, 2002).

of social assistance rates, insufficient disability assistance rates, divestment of federal funding from housing, and an overall reduction of social welfare services (Morrow, Dagg, & Pederson, 2008; Morrow, Frischmuth, & Johnson, 2006). The erosion of the social safety net has contributed to increased rates of poverty, homelessness, health issues, including mental health and substance use issues (Morrow, Dagg, & Pederson, 2008; Morrow, Frischmuth, & Johnson, 2006).

Health care and social welfare restructuring was and continues to be profoundly influenced by increasing neoliberal orientations of government and health authorities²² (Boyd & Kerr, 2016). Neoliberalism subscribes to principles of privatization, deregulation, decreased taxation, cost-effectiveness and efficiency, valuing notions of social and economic self-sufficiency (Rioux & Riddler, 2011). Ideologically, neoliberalism favours reduced government and social expenditure in relation to public programs such as health care and social assistance, placing direct responsibility on individuals for their health and mental health outcomes (Berghmans, de Jong, Tibben, & de Wert, 2009; Pauly, 2008).

In relation to health care specifically, neoliberal orientations construct good citizens as those “who take responsibility for making choices that do not burden the health care system with inappropriate requests for costly and unnecessary services”, and fiscally responsible health policies as those promoting reduced reliance on public programs and resources (Teghtsoonian, 2009, p. 31). The argument of resource scarcity endorsed by neoliberal ideology further promotes dialogues of competition and deservedness, seeking to define who warrants access to health care, including the types of services made available (Berghmans, de Jong, Tibben, & de

²² Neoliberalism was introduced in the 1980's and has since become a dominant global discourse.

Wert, 2009). Neoliberal orientations divert attention away from addressing social and structural issues of access and inequity, emphasizing individual-level variables (such as: self-care practices, lifestyle, choice, exercise, diet, substance use, and level of treatment engagement and/or ‘compliance’) (Teghtsoonian, 2008, p. 33). Neoliberal orientations to mental health, mental health treatment and legislation remain prevalent throughout Western liberal democracies today.

Mental health and psychiatric treatment was, and continues to be, heavily influenced by ableism²³. Ableist discourse portrays individuals with MHIs as incompetent, un-trustworthy, irrational, lacking the capacity to make informed decisions, violent as well as maintaining less inherent value in comparison to those without MHIs (Groves, 2011; Nash, 2013). MHIs are further deemed abnormal and interpreted as ‘dysfunctional’ and ‘maladaptive’ according to social values and norms of productivity, self-sufficiency, individualism, ability and ‘rationality’ (Crowe, 2000). Such harmful stereotypes and ableist assumptions have legitimized and formalized intrusive and nonconsensual psychiatric interventions throughout history, and at times continue as justifications for involuntary and coercive treatment practices. While perceptions of people labelled with MHIs have changed overtime, ableism remains prevalent today, legitimizing the continued devaluation and discrimination against persons with MHIs on individual and systemic levels.

In Canada, conceptualizations of mental health and psychiatry also occurred within the context of ongoing colonization of Indigenous peoples, cultures and lands. Colonization continues to have catastrophic effects on Indigenous peoples across Canada (Boksa, Joobar, &

²³ Ableism is defined as discrimination based on mental or physical disability – which includes use of and reliance on stereotypes.

Kirmayer, 2015; Kanani, 2011). In BC, Indigenous people identified and labelled as having MHIs were displaced from their communities and warehoused in institutions, such as BC's Essondale (later renamed Riverview Hospital) (Menzies & Palys, 2006). Racist stereotypes identifying Indigenous peoples as “troublesome, obdurate, wild, abusive, resistive, or otherwise indecipherable” were used to justify and normalize assimilation practices and non-consensual psychiatric intervention – including, but not limited to, practices such as lobotomies and solitary confinement (p. 161). According to Menzies and Palys (2006), Indigenous people in BC were most often labelled as having MHIs due to breaching “social and racial conventions” (p. 166). Willingness to assimilate and ‘comply’ with ward rules and treatments was an indicator of recovery and potential liberty from involuntary treatment and institutionalization (2006). Menzies and Palys (2006) state that the majority of Indigenous people “... who entered the British Columbia mental health system” between 1879-1950 were “effectively [given] a sentence of death”²⁴ (p. 166).

The particular ways in which MHIs are conceptualized within health policy and legislation, including established health care services, are predominantly determined and influenced by the social, political, and economic needs of colonial European settlers rather than the needs of the various Indigenous communities they may affect (Czyzewski, 2011). Conceptualization of mental health and psychiatric treatment in BC and across Canada continue to rely on and associate “...specific diseases with ‘lifestyles’... avoiding references to colonial legacies that shape either personal life choices or health care practices” (Fiske & Browne, 2008, p. 14). According to Kanani (2011), psychiatry has yet to acknowledge “the violence of dispossession,

²⁴ Half of the recorded deaths were due to Tuberculosis, and one third of deaths were caused by bacterial infections (Menzies & Palys, 2006). Average age of death was 47 (Menzies & Palys, 2006).

segregation, exclusion, or cultural genocide that characterize the process of colonization as causal factors for mental illness in Aboriginal people” (p. 6). Colonization is an ongoing process which continues to affect the conceptualization and treatment of MHIs for Indigenous peoples across Canada.

Intersecting with racialized inequities, discrimination based on gender and sexuality also heavily influenced conceptualization of MHIs and psychiatric treatment. According to Dyck (2011):

In the era after the asylum, ... gendered distinctions remained firmly in place, even as the walls of the institutions dissolved from the picture. Acceptable displays of masculinity and femininity, often characteristics infused with ideals of sexuality, continued to shape the ways that mental disorders were understood and addressed. (p. 184)

Women remain more likely to have their mental health pathologized in comparison to men (Hill & Needham, 2013). Diagnosis of MHIs also continues to maintain gendered assumptions and stereotypes; women remain more likely to be diagnosed with depression and anxiety, whereas men are more likely to be diagnosed with antisocial personality disorder and substance use issues.

Such gendered distinctions continue even though “results from national studies of overall psychopathology or ‘any disorder’ are, at best, mixed and limited to a narrow range of mental health conditions” (Hill & Needham, 2013, p. 83). People presenting as gender non-conforming also have and continue to experience pathologization of their mental health due to gendered assumptions and societal expectations regarding gender presentation and performance (Drescher, 2010). Psychiatry continues to be influenced by and rely upon gendered distinctions for the diagnosis and treatment of MHIs across the Western world.

Increased reliance on involuntary and coercive psychiatric treatment practices are in part due to a lack of early intervention and prevention based community services. According to the Canadian Mental Health Association (2017), many preventable situations escalate before meaningful care of MHIs is provided, justifying violation of rights and freedoms via the MHA. Publicly funded community mental health services remain scarce and difficult to access due to long waitlists and restrictive entrance criteria (MHCC, 2012). Private services – such as psychotherapy - must be paid for by patients or private third-party insurance, but remain financially inaccessible for many people²⁵ (MHCC, 2012). These factors make it difficult to access adequate and consistent mental health supports 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.

Diagnosis and the *Diagnostic and Statistical Manual of Mental Disorders*

CST draws attention to assumptions of what is constructed and defined as normal, abnormal and pathological (e.g. Canguilhem, 1991). Notions of normality, abnormality including MHIs, are socially and historically constructed²⁶ (Canguilhem, 1991; Rose, 2006), meaning, these concepts are created through shared social understanding within a given time, and not seen as a consequence of individual variance (Walker, 2006). MHIs are discursively constituted as abnormal and pathological as they are deemed ‘dysfunctional’ and ‘maladaptive’ according to social values and norms of individualism, productivity, self-sufficiency, ability and ‘rationality’

²⁵ Although “patient preferences across diverse settings yielded a significant three-fold preference for psychological treatment relative to medication” psychotherapy continues to be under utilized, if at all, in hospital settings (McHugh, Whitton, Peckham, Welge, & Otto, 2013, p. 596).

²⁶ Noting that the social and historical construction of MHIs does not negate the occurrence of mental distress, rather it highlights how this phenomenon is created and understood while simultaneously being altered over-time by social norms and dominant discourses (Roberts, 2005).

(Crowe, 2000). Rose (2006) proposes MHIs as “a norm against which experience can be judged as abnormal, and a set of beliefs and words to enable it to be understood and communicated” through psychiatric discourses of diagnosis (p. 480).

The *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)* is the classification system used to define and diagnose MHIs (American Psychiatric Association, 2013). According to the British Psychological Society (2011), the criteria used within the *DSM* “are not value-free and largely based on social norms reflecting current normative social expectations... with 'symptoms' that all rely on subjective judgments, with little confirmatory physical 'signs' or evidence of biological causation” (p. 5). The diagnostic process has been critiqued for locating problems within individuals, without considering the relation and social causation of such issues (British Psychological Society, 2011). Contemporary Western understandings of MHIs remain dominated by psychiatric discourse, with psychiatry deriving its medical authority and approach to MHIs through its adoption of the biomedical model.

The biomedical model situates people diagnosed with MHIs as "personal pathologies that can be diagnosed and treated through the allegedly value-free traditions and naturalistic methods of science and medicine” (Bryant, Raphael, & Rioux, 2010; Esposito & Perez, 2014, p. 415). It assumes that ‘abnormal’ psychological experiences result from neurobiological deficits or genetic abnormalities, necessitating medical and/or chemical intervention (Abramowitz, 2015; Deacon, 2013). The biomedical model therefore relies heavily on prescription and pharmaceutical interventions as the primary form of mental health treatment (Rose, 2006). This individualized pathology approach seeks to prevent illness through promotion of behavioural and lifestyle changes (such as smoking cessation, exercise programs, stress reduction and abstinence from drugs), that emerge from defining health and mental wellbeing as the absence of illness or

disease (Raphael & Bryant, 2010). By excluding social and structural influences of MHIs, psychiatric and biomedical discourses reinforce notions of individualism, primarily emphasizing diagnosis and pharmaceutical treatment alone.

In relation to MHIs, discursive structures operate in complex and contradictory ways. Diagnoses facilitate communication and shared understanding among physicians and nurses through a common classification system, promoting a uniform and evidence-based approach to care and treatment (Lemperiere, 1995). Providing mental health diagnoses also assists individuals in obtaining disability assistance – furthering incentive for practitioners to diagnose and for service-users to seek a diagnosis (Brinkmann, 2016). Defining a group or characteristic as abnormal has also led to the populations’ stigmatization, pathologization, and experiences of discrimination (Shier & Sinclair, 2011), with serious social implications for their autonomy, agency, safety and humanity. People with MHIs are frequently portrayed and perceived as incompetent, irrational, untrustworthy, violent, lacking the capacity to make informed decisions, as well as maintaining less inherent value in comparison to those without MHIs (Groves, 2011; Nash, 2013). Mental health diagnoses can legitimize the use of paternalistic practices, such as the lack of capacity assessment for consent or consent for treatment, including any potentially coercive treatment in the name of societal protection and/or the ‘best-interest’ of the service-user.

Conceptualization of MHIs in BC and Canada continue to be influenced by the socio-historical context from which they arose. This includes biomedical conceptualizations of MHIs, neoliberal orientations of government and health authorities, ableism, ongoing colonialism, and gendered distinctions. Alongside these dominant conceptualizations and approaches to mental health, there have also been movements throughout history influencing and reforming such dominant understandings and approaches. Historical and current trends include grassroots

movements championing peer-run services and promotion of rights protections, social models of mental health and disability, recovery-oriented approaches, harm-reduction, trauma and violence informed care, culturally safe care, and equity-oriented care (Browne, Varcoe, Ford-Gilboe, & Wathen, 2015; Government of Canada, 2018; Hoffman, 2008; Josewski, 2012; Mancini & Linhorst, 2010; Slade et al., 2014). While these approaches and models are applied to mental health treatment in varying degrees across the mental health system in BC, implementation of programs and types of treatment continue to be heavily biomedically and psychiatrically oriented, colonial, ableist and neoliberal in their approach and construction of MHIs²⁷ (Deacon, 2013; Slade et al., 2014).

Construction of the Mental Health Act

BC's first MHA was created in 1964 (Yearwood-Lee, 2008). The MHA was created through the consolidation of five previous laws, which included: the *Clinics of Psychological Medicine, Schools for Mental Defectives Act, Mental Hospitals Act, the Provincial Mental Health Centres Act, and the Provincial Child Guidance Clinics Act*²⁸ (Government of British Columbia, 1964). As previously mentioned, the MHA was established during the process of deinstitutionalization with the intention of facilitating treatment within the community context (Yearwood-Lee, 2008). Although institutional care for people with MHIs is no longer prevalent

²⁷ As outlined by Deacon (2013), “individuals and organizations who publicly question the efficacy of psychiatric medications, the validity of *DSM*-defined mental disorders, or the scientific basis of brain disease theories of mental disorder[, including involuntary treatment] are often dismissed as ignorant, incompetent, and dangerous” (p. 856). Positioning critique or resistance against dominant mental health discourses in an adversarial and polemical manner discredits legitimate contributions to the dialogue of mental health, treatment, patient experiences and nursing practice.

²⁸ Although it is beyond the purview of the paper to review each Act individually, it is important to note that these laws included the authority to involuntary detain and ‘treat’ people with MHIs beginning with the *Insane Asylums Act* in 1872 – adopting much of England’s *Lunatic Asylum Act* (Yearwood-Lee, 2008). For an in-depth overview of these laws, please refer to the work of Dr. Gene Fraser (2015).

in BC, the MHA by extension continues to negotiate “the line between social support and coercive control” (Boyd & Kerr, 2016, p. 425; Morrow, Dagg, & Pederson, 2008).

Prior to the enactment of the MHA in 1964, people with MHIs were admitted for involuntary treatment through physician’s orders and judicial endorsement (Fraser, 2015). The 1964 MHA transferred the need for judicial oversight for committal orders solely to physician discretion. The 1964 Act required two physicians to confirm a person was in need of medical or psychiatric treatment and/or for the “care, supervision, and control in a Provincial mental health facility for his [sic] own protection or welfare or for the protection of others” (Fraser, 2015, p. 52). The 1964 MHA furthermore provided the option for the application to a review panel if a patient was seeking to challenge their involuntary status. A review panel is a process whereby the involuntary patient faces a panel composed of three people²⁹, who “decide, after a hearing, whether a patient should be discharged from involuntary status” (Ministry of Health, 2005, p. 43). This Act furthermore “eliminated reference to lunacy, insanity, idiocy and imbecility” as per previous mental health related policies and legislation “and instead referred to a patient as a ‘mentally disordered person’ or a ‘mentally ill person’” (Fraser, 2015, p. 51). Like other provinces at the time, the BC MHA of 1964 was identified as utilizing the “‘beneficence’ model of mental health care”, relying upon medical paternalism for decisions making (Fraser, 2015, p. 52).

The MHA was revised in 1979. According to Fraser (2015), the 1979 MHA was substantially similar, “except that the new legislation allowed patients, pursuant to Section 21, to apply for review of the committal order one month following the initial detention (rather than

²⁹ The review panel was composed of strictly physicians at this time.

three months under the predecessor Act) and the review panel no longer consists of two physicians, but rather ... three members: a lawyer who acts as chair, a physician and a community member” (p. 58). Changes to the MHA did not occur again until 1996, when provisions included “extended leave of patients who remain under civil commitment orders but [were]... permitted to live in the community”, reflecting the initial purpose of the MHA – community treatment provisions (p. 58). The 1996 MHA also required review panel hearings to take place no later than 14 days following application, including periodic review upon completion of renewal certificates (2015).

Amendments to the MHA also took place in 1998 regarding involuntary committal criteria, hospital admission and release (Fraser, 2015; Yearwood-Lee, 2008). The amendments allowed “psychiatrists to impose involuntary medical treatment on patients whom they believe[d] ... [were] are at risk of deteriorating without medication, even though the patients [were]... mentally capable of making treatment decisions for themselves and ... not at risk of harming themselves or others” (Fraser, 2015, p. 59). Johnston (2017) further notes that:

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. 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. (p. 23)

These legislative changes occurred simultaneous to “the remarkable growth in psychiatric power and the sharp increase in the use of psychiatric medication” (Fraser, 2015, p. 59-60). According to Fraser (2015), these amendments solidified “neurobiological forms of thinking shap[ing] the law, which then in turn codified that thinking and reinforced it through regulations, directives and documentary forms used by psychiatrists, hospitals and law enforcement agencies” (p. 60). This also greatly influenced the manner in which nurses practiced within mental health settings³⁰.

Minor revisions to the MHA also occurred in 2018 by the Mental Health Review Board, specifically in relation to *Form 7: Application for Review Panel*. These revisions were in part a response to the outcomes of the Community Legal Assistance Society’s (CLAS) report, exposing the violations occurring for people deemed in need of involuntary treatment (Cheung, 2018; Johnston, 2017). According to Cheung (2018), amendments to Form 7 included information pertaining to review panels, how to obtain legal representation, instructions for completing the form, the patient’s certification and renewal dates, and the addition of a field for the patient’s contact information. The intentions of the revisions were to ensure maintenance and promotion of patient rights pertaining to the review panel process (Mental Health Review Board, 2018). While seemingly well-intentioned, Cheung (2018) argues that these revisions were made in complete isolation from patients, with no consideration paid to making the information

³⁰ Ways in which the biomedical model and psychiatry have affected mental health nursing practice are discussed in further depth in Chapter 4 and Chapter 5.

accessible - Form 7 continues to use complex legal discourse and provides unclear instructions for service-users and practitioners³¹.

The Guide to the MHA was developed by the Ministry of Health “in consultation with individuals, families, police, physicians, other health care professionals and advocacy and service organizations” (Ministry of Health, 2005, p. iv). The initial Guide was published in 1997, with a revised version released in 1999 which included amendments made to the MHA in 1998 (Ministry of Health, 2005). According to the Ministry of Health (2005):

The third and current edition was developed to include some legislative changes, to provide more information on the application of the Act in communities through its ‘extended leave provisions,’ and to provide greater clarity and plain language descriptions on a number of key sections of the Act, which were identified by service providers and stakeholders during extensive consultations³² on the Guide. (p. iv)

The MHA is “administered by health authorities, who are in turn accountable to government ministries, such as the Ministry of Health” (Johnston, 2017, p.5). The MHA can be accessed online by the BC laws website. Healthcare practitioners, such as nurses and physicians, must collectively implement the MHA. The interpretation of the MHA however is subjective. For example, “need for protection” is not defined in the MHA, and the Guide refers to a very broad definition of protection³³ which does not provide direction for healthcare practitioners. Nurses and physicians must therefore engage in inferential work to know when protection through involuntary treatment under the MHA is justified. Interpretive implications could lead to

³¹ For a detailed overview of changes made to Form 7, please refer to Cheung (2018).

³² Process, length or number of consultations are not signified in the Guide.

³³ Definition used by Guide is provided in Chapter 4.

the over- or under-utilization of involuntary treatment; people who may be in need of involuntary treatment can be overlooked, while others may be involuntarily committed inappropriately.

The Guide is accessible online through the Government of BC website. Because healthcare practitioners are not personally directed to this resource it is up to the individual practitioner as to whether they read, reference or use it. According to the Ministry of Health (2005), the Guide was created for the purposes of “making the Act more understandable; and promoting consistency in interpreting the Act so people who need involuntary psychiatric treatment receive help in a responsible and lawful manner” (p. iv). The Guide provides interpretations of the Act in order to reduce the amount of inferential work that is needed when employing the MHA, such as clarifying what “in or through” a designated facility means as per Form 4 – being “that a patient initially requires inpatient treatment as an involuntary patient, but may subsequently be placed on leave and continue to receive psychiatric treatment in the community” (Ministry of Health, 2005, p. 8). However, absences within the MHA itself are often not addressed in the Guide – as will be exemplified in Chapter 4.

Legislation and Discourse

According to Fairclough (2009), “with respect to the dialectic between texts and other elements of social events, the general point is that political texts are not some superficial embroidery upon political events but a fundamental, constitutive, part of them” (p. 179). The manner and types of discourses utilized act to shape the text of legislation which in turn shapes the construction, interpretation and implementation of laws. In relation to BC’s MHA, the legislation provides conceptualizations and manners of engagement regarding people identified with a “mental disorder” who are deemed in need of involuntary treatment.

According to Fairclough (2009), discourse is dialectical and therefore incapable of being removed from the power, values and belief systems of a particular socio-historical context; legislation maintains the power to shape identity and social institutions (Foucault, 1991). The MHA exerts force through hidden assumptions embedded within the MHA itself, in concert with the values and beliefs held by greater society. Forms within the MHA further produce categories of people to sort how they should be acted upon and dealt with. Since legal discourse is often inaccessible, difficult to understand and therefore difficult to implement into practice, the Ministry of Health created the Guide to the MHA (2005). The MHA and Guide rely on ‘naturalization’ – a practice of presenting information as ideologically neutral – removing comprehension of coercive practices and routines as practices which have “ideological effects on the society” (Ahmadvand, 2011, p. 7).

Summary

This chapter provided a brief historical overview of shifts in socio-cultural understandings of mental health, MHIs, diagnosis and mental health treatment in Canada. This overview also included the socio-historic events and forms of discrimination impacting the conceptualization of MHIs and mental health treatment. This chapter outlined how these events and forms of discrimination informed the discursive context under which the MHA and Guide to the MHA were created. Without understanding these events, alongside the individual and structural experiences of discrimination, we are unable to understand their impact on people experiencing MHIs and their implications, especially in relation to the MHA in its current form.

Chapter 4: Protection and the Protectors

Roles of Social Actors and the Enactment of Protection

Social actors are individuals or groups that participate in social practices (Van Leeuwen, 2008). Positioning of social actors is dialectically created and reproduced between people, institutions and society through discourse, systematically forming and informing “the objects of which they speak” (Foucault, 1972, p. 49). Discourses represent and position social actors “in particular ways and in certain discursive and social contexts” to maintain a specific social order (Koller, 2009, p. 75). CDA helps “bring to light ... [the] systematic omissions and distortions in representations” (Van Leeuwen, 1993, p. 194).

One central discourse and its effects were identified during the CDA of the Act and Guide. These included the discourse of protection and the positioning of service-users. Protection is constructed in a particular manner and is enacted through application of MHA forms by physicians, nurses and police officers and is the central discourse employed by these texts to justify involuntary and coercive treatment. The Act and Guide were found to position service-users in a particular manner, laying the groundwork for further normalization and justification of the abusive power relations that maintain social inequity for mental health service-users.

In this chapter I explore how protection is constructed in the Act and Guide. I go on to explore how protection is enacted by social actors (physicians, nurses and police) through the implementation of MHA forms. I furthermore explore the positioning of involuntary service-users. Note that since the MHA and Guide utilize the term *patient* to refer to service-users receiving involuntary treatment, I will retain this term throughout the rest of my thesis.

Constructing Protection

According to the MHA and Guide to the MHA, one of the criterion for involuntary treatment is the requirement of “care, supervision and control in or through a designated facility to prevent the person’s substantial mental or physical deterioration or for the person’s own protection or the protection of others” – as per *Form 5: Consent for Treatment (Involuntary Patient)* (Ministry of Health, 2005, p. 8). The term “protection” is used throughout both texts in relation to patients, “others” (the public), patient rights, and liability of healthcare practitioners. While the MHA and the Guide to the MHA do not provide a definition of protection, the concept and practice of protection is constructed in a specific manner (Ministry of Health, 2005). The Guide to the MHA (2005) references the BC Supreme Court case of *McCorkell v. Riverview Hospital* (1993) for the interpretation of protection, where the judge stated:

I agree with [the]... argument that the Manitoba criteria bear a close similarity to the British Columbia standard. In the Manitoba legislation, ‘serious harm’ is not qualified; it can include harms that relate to the social, family, vocational or financial life of the patient as well as the patient’s physical condition. The operative word in the British Columbia Act is ‘protection’ which necessarily involves the notion of harm. (p. 298-299)

This ruling clarified that the ‘need for protection’ goes beyond that of physical dangerousness alone, including: “threats, violence, paranoid delusions, command hallucinations, irrational wasting of money, deteriorating physical condition, likelihood of or losing a job, dropping out of school, grossly unsanitary living conditions, and suicidal ideas or behaviours” (Ministry of Health, 2005, p. 67). Such a broad interpretation of protection referred to within the Guide means any behaviour deemed a risk or mental health concern can be evidence for legitimizing

protection through involuntary treatment, depending on the healthcare practitioner's interpretation of symptoms and behaviours.

Protection is stated to promote safety through risk reduction by means of compulsory treatment (Ministry of Health, 2005). Protection is enacted through the containment of the person experiencing MHIs in a designated "in-patient facility" - typically a locked unit (Ministry of Health, 2005, p. 73). Directors, physicians, judges and police officers have the power to apprehend and detain a person for involuntary treatment. Healthcare practitioners, such as physicians and nurses, are provided the power to implement and enforce 'protection' through compulsory treatment formalized by the MHA.

The MHA defines treatment as "safe and effective psychiatric treatment and includes any procedure necessarily related to the provision of psychiatric treatment" (MHA, 1996, p. 3). Treatment is diagnosis dependent and primarily entails psychiatric medication, psychotherapy, and treatments such as ECT. As per the criteria on Form 4, treatment is compulsory for all involuntary patients. Expressed wishes are not addressed in the Act or Guide, leaving it to the physician's discretion to consider treatment preferences (Ministry of Health, 2005). The patient receiving involuntary treatment is expected to comply with the treatment decisions regardless of whether their specific needs or interests have been considered (Pelto-Piri, Engström, & Engström, 2013). Treatment is understood as being enacted in the 'best-interest' of the patient (Ministry of Health, 2005). If there are issues with "treatment compliance", various practices are enacted, such as the withholding of personal clothing, the use of seclusion rooms, chemical and/or physical restraints (Ministry of Health, 2005). Guidelines for such practices are not addressed in the Act, rather healthcare practitioners are told to refer to policies unique to their facility (Ministry of Health, 2005).

How is Protection Enacted and by Who?

The Physician's Role

All decision making authority is placed with the director and/or treating physician throughout the involuntary treatment process. A physician confirms whether the patient fulfills the criteria for involuntary admission on *Form 4: Medical Certificate (Involuntary Admission)*. Criteria for involuntary admission include: an individual who “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”; “requires treatment in or through a designated facility”; “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 “cannot suitably be admitted as a voluntary patient” (MHA, 1996, s. 22). The person under examination must fulfill all criteria for involuntary treatment and furthermore requires “active treatment” – referring to administration of psychiatric medications (MHA, 1996; Ministry of Health, 2005). Form 4 provides authority for anyone, including members of the public, to apprehend the person and transport them to a designated facility.

Upon apprehension and transportation to the designated facility, the person, now deemed “patient” can be detained for up to 48 hours. A second physician can sign an additional Form 4 if they are of the “opinion” that the patient continues to fulfill Form 4 criteria – extending detention for up to one month. The second medical certificate (Form 4) must be completed within the first 48 hours upon admission, otherwise the patient must be discharged (Ministry of Health, 2005). For the patient to be detained beyond one month, a physician authorized by the director must sign *Form 6 – Renewal Certificate*. Form 6 can be signed if the physician has “formed the opinion” that Form 4 criteria “continue to describe the condition of the patient; and (2) that this

patient's status as an involuntary patient should be renewed", extending involuntary detention for up to one month from date of admission (MHA, 1998, s. 24). The criteria for renewal are the same as *Form 4: Medical Certificate (Involuntary Admission)*, however also include consideration of the "patient's history of hospitalization and treatment compliance" and the likelihood of compliance upon discharge (Ministry of Health, 2005, p. 79). Renewal of certificates through Form 6 occur within the subsequent intervals: an additional one month, followed by a three month and then six-month period – where upon all successive durations are reassessed before 6 months' time (Ministry of Health, 2005). Reassessment must occur as close to the renewal date as possible, however renewal can occur as early as one month in advance of the termination date (MHA, 1996). There is no limit on the length of involuntary treatment (Johnston, 2017).

Form 4 and Form 6 utilize biomedical and psychiatric discourses to identify and define MHIs as "disorders of the mind" (MHA, 1996, s. 2). Since the biomedical model defines health and mental wellbeing as the absence of illness or disease, emphasis remains centered on curing "as the measure of success" (Storch, Rodney, Pauly, Brown, & Starzomski, 2002; Pauly, 2008, p. 210). In psychiatry, this emphasizes diagnosis and pharmaceutical treatment of the individual (Rose, 2006). Favoring the absence of disease or illness positions those experiencing 'unwellness' as less (mentally and/or physically) capable of contributing to society and therefore maintaining less inherent value in comparison to those identified as 'healthy' and 'able'. These narratives of abledness, productivity and profit-potential are tied to discourses of capitalism and neoliberalism. People with MHIs are therefore seen as being in need of rehabilitation to live 'healthy and productive lives', which in part entails being employed, not relying on the social safety net and contributing to the economy.

The criteria on Form 4 and Form 6 have been criticized for being overly broad (Groves, 2011; Johnston, 2017). According to Groves (2011), “although the argument is often made that broad admission criteria are needed to provide effective care to vulnerable people, the imprecision of the current criteria can in fact work against effective protection” (p. 3). For example, broad criteria allow for either the over-inclusion or under-inclusion of people experiencing MHIs depending on the physician’s interpretation of the criteria; some people have been denied involuntary psychiatric treatment and deteriorated to the point of suicide or harm, while others have experienced involuntary treatment even though they maintained capacity to consent (Groves, 2011). Form 4 and Form 6 furthermore do not separate admission from treatment; once admitted, a patient necessitates “active treatment” (being psychotropic medication)³⁴. Currently, there are no mechanisms in place to ensure consistency or appropriate application of Form 4 and Form 6. There is also “no mechanism to ensure a minimum level of periodic automatic review” of involuntary treatment and detention unless the patient applies for a review panel³⁵ (Johnston, 2017, p. 22).

According to the MHA, protection of the patient and greater society can thus occur for indefinite periods of time if deemed necessary by the treating physician. Unless patients under involuntary treatment “apply for a review panel, they can be detained for the remainder of their life without an independent review of the detention”³⁶ (p. 22). Johnston (2017) found that due to

³⁴ In Ontario, “admission and treatment are viewed as two separate matters, with involuntary admission criteria related to probable physical and mental harm and/or deterioration, and involuntary treatment criteria related to capacity to consent ... [allowing for] an involuntary patient [to]... still refuse treatment if they were found capable of making such a decision” (Schizophrenia Society of Ontario, 2013, p. 28).

³⁵ Review panels are now composed of a lawyer, a healthcare practitioner, and a person who is not a lawyer or healthcare professional, who are appointed by the Minister of Health (Ministry of Health, 2005).

³⁶ As indicated by Johnston (2017), “several other Canadian jurisdictions mandate that periodic reviews be conducted automatically” such as Alberta, where the “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” (p. 22).

class bias, “affluent people were more likely to be released because they had access to safe housing and appropriate supports”, whereas, “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” (p. 39). Unfortunately, there is no data available outlining to what extent this occurs in practice, allowing for such patterns to remain unacknowledged and maintained.

The construct of protection is also extended into the community through the provision of *Form 20: Leave Authorization*, also known as Extended Leave. As per the Guide to the MHA (2005), Extended Leave “is intended to be a client-centered therapeutic intervention used to” ensure the earliest possible release of an involuntary patient from hospital and “optimize an involuntary patient’s potential for community living through the provision of support for treatment compliance once out of hospital” (Ministry of Health, p. 29). Extended Leave is considered for patients who require “reinforcement for/ support for compliance” in the community setting who are experiencing a “psychiatric diagnosis with a high severity” and present behaviours which place them or others at “risk of harm”, while exhibiting “non-compliance which is intentional and/or due to lack of insight” – especially in relation to “medication”, which results in repeated hospitalizations (p. 29). Extended Leave can only be issued if the person has been hospitalized or treated previously on an involuntary basis (Grey, Weller, & McSherry, 2010; Ministry of Health, 2005).

The treating physician initiates Extended Leave. The patient is asked to sign Form 20 “to confirm that the leave conditions have been explained”, however the patient’s “signature is not required to authorize leave” – rendering consent meaningless (Ministry of Health, 2005, p. 30). Deemed consent continues from the in-patient to community setting (Johnston, 2017).

Psychiatric treatment is transferred to an appropriate service in the community where the patient can be “actively monitored for compliance with treatment” (Ministry of Health, 2005, p. 30). As per the MHA (1996), Section 39 (1):

The release of a patient on leave ... under section 37... does not, of itself, 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. (p. 21)

In order to remain in the community, the patient on Extended Leave must be compliant with orders mandated by the treating physician. Such orders typically include the continuation of medication, attendance of appointments, and/or residing in an “approved home”, residing within a residential facility, and/or residing with a particular person (MHA, 1996).

While the intention of Extended Leave is to provide “a client-centered therapeutic intervention”, direct relation or engagement with the patient by the physician or nurse is only referenced on four occasions in the Extended Leave process for the Guide (Ministry of Health, 2005). These references include, “... review[ing] the feasibility of extended leave for a patient including discussion with the patient”, the signing of the form (which is not mandatory), informing the patient of information related to community treatment (also not mandatory), and finally informing the patient of their rights once in the community (Ministry of Health, 2005, p. 30). Direct engagement of the patient by the nurse or physician regarding Extended Leave is completely absent in the Act itself (MHA, 1996). Consultation and collaboration with the patients and their families in relation to Extended Leave is practically absent and further not obligated; rather, healthcare practitioners enacting involuntary treatment are centered throughout these texts, especially regarding the Extended Leave process.

According to Johnston (2017), “there is no way to seek review of decisions to place or recall a detainee on extended leave or the conditions of leave imposed” (p. 22). If the patient breaches conditions of leave, the director signs Form 21. The nurse assists police in locating and apprehending the patient, for transport to hospital (Ministry of Health, 2005). Extended leave “may continue as long as the involuntary status of the patient is maintained through correct renewal procedures, or until the patient is recalled to hospital, or discharged” (Ministry of Health, 2005, p. 33). The Mental Health Review Board may order a review panel hearing if the patient has been on Extended Leave for 12 months or more, however such occurrences are rare (Johnston, 2017; Ministry of Health, 2005). Some patients have experienced up to 10 years on Extended Leave without any form of review³⁷ (Johnston, 2017). Although briefly mentioned in the Guide, there is no explicit reference for compulsory treatment needing to be the least restrictive option possible within the Act (Grey, Weller, & McSherry, 2010).

Through Extended Leave, notions of protection and control are extended into the community context for patients who are deemed non-compliant (Kaiser, 2009; McWade, 2016; O'Reilly, 2004). The Schizophrenia Society of Ontario (2013) examined studies that “evaluated clinical outcomes for involuntary admission and treatment for both hospital admissions” and Extended Leave³⁸ (p. 31). Positive clinical outcomes included “reduced future hospital admissions; abstinence from drugs; reduction in homelessness; adherence to treatment (engagement and medication adherence); ability to identify decompensation earlier and prevent it from escalating to a point of crisis; and the ability to stay in the community” (Schizophrenia

³⁷ Data on the duration of Extended Leave is not specifically available since these rates are not tracked or collected by the Ministry of Health (Johnston, 2017).

³⁸ The studies examined included “Canada (mostly Ontario, some from Saskatchewan), the US, Australia, Scotland, Sweden, the Netherlands, Brazil, Europe and the UK” (Schizophrenia Society of Ontario, 2013, p. 31).

Society of Ontario, 2013, p. 32). Negative outcomes included: “higher relapse rates; future treatment avoidance; mistrust of the system; decreased future help-seeking behaviour; heightened perceptions of coercion (associated with client-perceived barriers to treatment); and longer length of hospital stays, with fewer improvements” (Schizophrenia Society of Ontario, 2013, p. 32). However, according to a Cochrane Database Systematic Review completed by Kisely, Campbell, and Preston (2011), “no significant difference[s were found] in service use, social functioning or quality of life [of involuntary Extended Leave patients] compared with [those receiving] standard [voluntary] care” (Kisely, Campbell, & Preston, 2011 p. 1). The only difference found for patients under Extended Leave was they were “less likely to be victims of violent or non-violent crime”, however the authors noted that it remained unclear “whether this benefit [was] ... due to the intensity of treatment or its compulsory nature” (Kisely, Campbell, & Preston, 2011, p. 1). The therapeutic benefits and outcomes of Extended Leave on involuntary patients remains contentious and debatable.

The Police Officer Role

Within the Act and Guide, “protection” is also enacted by police. *Section 28: Police Intervention*, provides authority to police to apprehend and bring the person to hospital for the purpose of receiving a mental health examination by a physician. Section 28 of the Act states that police may apprehend a person from secondary knowledge (provided by family, community members, or healthcare practitioners), and/or observations directly made by police of a person who is “apparently suffering from mental disorder”, and “acting in a manner likely to endanger their own safety or that of others” (MHA, 1996, p. 14). According to the Guide, the “‘safety’ element is a higher standard [for police] to meet than the criteria used by physicians”; however, this notion of ‘safety’ is not restricted to “the potential of physical violence to self or others”

(Ministry of Health, 2005, p. 13). Similar to the definition of protection suggested by *McCorkell v. Riverview Hospital* (1993), safety in relation to Section 28 also includes concerns with self-neglect and exposure to risk (Ministry of Health, 2005).

According to Dolman (2004), police intervention provides people with MHIs another point of access for involuntary treatment with the intention of “protect[ing] life and prevent[ing] injury” (as cited in Ministry of Health, 2005, p. 187)³⁹. Police intervention intends to assist people who do not have access to care and/or are not willing or are deemed incapable of consensually pursuing treatment on their own accord. Police intervention seeks to reduce the risk or potential of harm for individuals and the general public.

Triage forms have been developed by police organizations to assist police in determining whether apprehension under Section 28 is appropriate; use of triage forms are not compulsory and have only been implemented in specific communities (Ministry of Health, 2005)⁴⁰. Due to safety protocols, police must handcuff individuals apprehended under Section 28 during transportation to hospital. Police typically remain with the apprehended person until an examination has been complete - although the MHA itself does not provide any direction on this (Ministry of Health, 2005). The Act and Guide altogether fail to address whether people being taken to hospital via police intervention are to be informed of their rights (MHA, 1996; Ministry of Health, 2005). If the person brought in by Section 28 fulfills the criteria on Form 4 they are subsequently involuntarily admitted. If the person does not fulfill Form 4 criteria they are released from police custody. Police apprehension is justified through ‘enhancing and protecting’ public safety.

³⁹ Original source by Dolman (2004) not publically available.

⁴⁰ More current triage forms for involuntary mental health apprehensions are not publically available. Triage form referred to is provided in the Guide (Ministry of Health, 2005).

If the patient leaves the hospital without permission while involuntarily admitted, police may return them to hospital without a warrant within a 48-hour period. After this period, the director may issue a *Form 21: Director's Warrant (Apprehension of Patient)* to receive assistance from the police. This warrant is valid for up to 60 days, after which the patient is deemed discharged, “except if the patient (a) left the facility while charged with an offence, (b) is liable to imprisonment or (c) is considered by the director to be dangerous to self or others” (Ministry of Health, 2005, p. 53). If “an involuntary patient is recalled during the first 6 months of leave, the involuntary status of the patient continues in hospital without interruption”, after 6 months of leave the renewal process is re-started (p. 38).

Since police “are afforded the power to apprehend a person based on their observation” and subjective interpretation of behaviour, the application of Section 28 relies on mental health profiling (Wilson-Bates, 2008, p.1; Ontario Human Rights Commission, n.d.). According to the Ontario Human Rights Commission (n.d.), “mental health profiling is any action taken for reasons of safety, security or public protection that relies on stereotypes about a person’s mental health or addiction instead of on reasonable grounds, to single out a person for greater scrutiny or different treatment” (para. 1). Mental health profiling relies on stereotypes which often emphasize dangerousness, legitimizing police intervention (Menzies, 1987).

Similar to the application of Form 4 and Form 5, people experiencing economic and social marginalization experience disproportionate levels of police intervention under Section 28. This is in part due to mental health profiling. For example, according to the Ontario Human Rights Commission (n.d.), “people with mental health issues who are Aboriginal or from racialized communities may be more likely to be profiled as a security risk than other people” (para. 6). However simultaneously, people experiencing various and intersecting forms of structural

violence living in certain communities – such as Vancouver’s Downtown Eastside, may be overlooked by police for apprehension under Section 28 even though they may be in need of mental health intervention and treatment. Widely circulating discriminatory and stigmatizing discourses may predispose police to perceive certain populations as untreatable and disposable, relating deterioration to their environment and lifestyle choices (such as: substance use, poverty, homelessness).

Boyd and Kerr (2016) found that reports⁴¹ produced by the Vancouver Police Department regarding mental health “support and advance” (Boyd & Kerr, 2016, p. 13) biomedical and criminal frameworks that work against the “social and structural understandings of mental health” (Ingram, Lasik, Cormier, & Morrow, 2013, p. 9). Without acknowledging the impacts of structural violence (such as poverty, homelessness, inadequate housing, ongoing colonization, discrimination – such as racism and ableism, and the criminalization of substance use) towards mental health, the use of surveillance, police presence and police apprehension will continue to be relied upon to address MHIs within dominant discourses. Such structural inequalities are “avoidable, ... socially produced and structurally driven” and are not effectively dealt with on an individual basis (Boyd & Kerr, 2016; Ingram et al., 2013, p. 8).

The Vancouver Police Department identified that as of 2008, police are being increasingly relied upon for apprehensions due to issues related to insufficient community resources for mental health and substance use issues (Wilson-Bates, 2008). Concerns have been raised about relying on police intervention due to inadequate mental health training and education of police (Coleman & Cotton, 2010). Although the majority of police interactions with people with MHIs

⁴¹ Refer to Boyd and Kerr (2016) for more information about the Vancouver Police Department reports regarding mental health.

are resolved without use of force, violent and at times fatal outcomes for people with MHIs continue to occur across Canada (Coleman & Cotton, 2010)⁴². People with MHIs are three times more likely to come into contact with police (Coleman & Cotton, 2010), and are more likely to be charged for minor offences such as jay walking and loitering in comparison to the general public (Hartford, Heslop, Stitt, & Hoch, 2005; Lurigio, 2011). According McLean and Marshall (2010), 20 - 40% of those with acute MHIs will be arrested in their lifetime. An overwhelming “half of all police-involved fatal shootings in the City of Vancouver [not just in the Downtown Eastside] ... [from] 1980 [to 2008] involved some sort of mental illness or depression on the part of the deceased person” (Wilson-Bates, 2008, p. 53). There remains a lack of transparency and accountability for “potential police error or misconduct” in relation to the harms and deaths of people experiencing MHIs (Boyd & Kerr, 2016, p. 9).

The power afforded to police provides increased opportunity for involuntary treatment, it simultaneously reinforces the stigmatization and criminalization of people with MHIs. This is due to the association of police enforcing protection through containment of violent, deviant, and/or ‘unlawful’ behaviour – enforcing social control⁴³. According to Boyd and Kerr (2016), “citizens without mental health concerns ... have a privileged relationship to public space, including the ability to both deny access to certain spaces and to call for the policing of those they perceive as ‘scary’ or untoward”; “... concerns for public safety, amplified by the popular and overriding association of mental illness with dangerousness, have local consequences,

⁴² Phuong Na (Tony) Du was shot and killed by police officers on Nov. 22, 2014 in Abbotsford, BC. According to witness testimonies, Tony was “screaming and waving a two-by-four” and experiencing mental distress (Correia, 2018, para. 2). The coroner’s inquest provided recommendations to improve police interaction with people experiencing MHIs through “training, education and agency information sharing”, however no charges against police were made (Correia, 2018, para. 1).

⁴³ Social control is maintained by removing and containing perceived or potential threats, incarceration, and/or application of charges.

validating increased policing of unwanted “others” in public spaces” (p. 12). Although power afforded to police may provide feelings of security and safety for some, it also increases the likelihood of detention, incarceration, involuntary mental health treatment, violence, and in extreme circumstances, death of people with mental health and/or substance use issues⁴⁴.

The Nurse’s Role

Nurses are positioned to enact protection and treatment through enforcement of the physician’s orders, implementing the everyday “care, supervision and control” of involuntary patients (MHA, 1996, s. 22). Enactment of protection includes regulatory practices, such as: enforcing psychotropic medication consumption, surveilling and reporting on symptoms and behaviors, as well as implementing coercive treatment measures (physical/chemical restraints, seclusion rooms and medication via injection) to enforce behavioural correction and compliance (Roberts, 2005). Nurses are also positioned to implement protection in the community setting, where they are responsible for “actively monitor[ing]... [the patient] for compliance with treatment” (Ministry of Health, 2005, p. 30). The nurse decides whether a patient should be recalled to hospital for breaching conditions of leave,⁴⁵ such as missing an appointment or declining to take medication (Ministry of Health, 2005, p. 30). The nurse assists police to locate and apprehend the patient for transport to hospital. Despite their significant role in practice, nurses are nearly absent in the Act and Guide⁴⁶ (MHA, 1996; Ministry of Health, 2005). Such

⁴⁴ According to the Canadian Mental Health Association (2005), “when police respond to a person in mental health crisis as they are trained to respond to a typical criminal emergency situation – with a show of force and authority – they may in fact escalate the crisis to a point of risking injury or death for police or the public, but most often for the person in mental health crisis” (p. 1).

⁴⁵ The nurse typically forms the case to recall a patient to hospital, and the director of the facility authorizes this decision by signing *Form 21- Director’s Warrant*.

⁴⁶ Nurses are referred to on three occasions in the Act and on five occasions in the Guide – the majority of references involve “the senior nurse on duty” (MHA, 1996; Ministry of Health, 2005, p. 3). Nurses are referenced in context to receiving completed Forms 7s (request for review panel hearing), having authorization to provide substitute consent

omission in effect obscures identification of those implementing and enforcing protection as per the Act and Guide. This omission, and therefore invisibility, is a function of power in that it removes accountability and obscures nurses as agents of enforcement.

In the Act and Guide, nurses are positioned to engage in correctional, punitive and therapeutic methods, which may be consistent with the MHA, yet are at odds with their professional responsibilities to advocate and preserve safety, autonomy, dignity and well-being of the patient. Such methods do not align with contemporary best-practices, such as trauma and violence informed care or harm reduction (Canadian Association of Schools of Nursing, 2015; Canadian Federation of Mental Health Nurses, 2014; Muskett, 2014)⁴⁷.

People implementing the involuntary treatment process, such as physicians, nurses, police, paramedics, and civilians “acting in good faith and with reasonable care” are protected by the Act from “being found liable for damages” (Ministry of Health, 2005, p. 11). As per Section 16 in the MHA, protection from liability includes performing functions within the Act such as: certification, “taking charge of the person”, warrant, apprehension by police, transportation, detention, “care, supervision, treatment, maintenance or rehabilitation of a patient”, leave authorization, as well as transferring or recalling a patient (MHA, 1996, p. 6).

The MHA safeguards all those involved in implementing the involuntary treatment process through protection from liability for legal damages for certain harms occasioned by their care.

Other than suing⁴⁸, patients have no recourse in relation to their involuntary treatment process or experience, which includes issues of maltreatment, malpractice, or permanent side-

as necessary for “consent forms for involuntary treatment or warrants”, authority to admit patients, as well as providing information regarding the review panel process (Ministry of Health, 2005, p. 3).

⁴⁷ Discussed in further detail in Chapter 5.

⁴⁸ Patients may also lose the right to sue depending on the circumstance and outcomes of involuntary treatment (Groves, 2011). A central barrier to taking legal action is cost.

effects (Groves, 2011; Johnston, 2017). Johnston (2017) notes that “robust protections against liability” involving the application of the MHA were formulated to ensure that physicians and nurses “are under no apprehension of any legal consequences for deciding to detain or not detain an individual”, including the outcomes of involuntary treatment (p. 23). According to Groves (2011), Section 16 is “overly broad and does not reflect previous case law that recognizes the entitlement ... to be informed of risks and benefits of proposed treatment and made aware of alternative treatments as well as ... [the] entitlement to a standard of care that is contextualized by ... [a] physician’s specialty” (p. 3). The manner in which these protections are designed promote a lack of accountability and deny possibility for recourse by involuntary patients.

The Patient’s Role

The MHA defines a “person with a mental disorder” as “a person who has a disorder of the mind that requires treatment and seriously impairs the person’s ability (a) to react appropriately to the person’s environment, or (b) to associate with others” (MHA, 1996, p.3). According to the Guide to the MHA, indications of a “mental disorder” may include “hallucinations, delusions, irrational thinking, manic excitement, depression or difficulty relating to others” (Ministry of Health, 2005, p. 72).

The MHA and Guide to the MHA refer to service-users admitted involuntarily as “patients” who are “received, detained or taken charge of as a person with a mental disorder or as apparently a person with a mental disorder” for purposes of “receiving care, supervision, treatment, maintenance or rehabilitation” (MHA, 1996, p. 2). While the term patient maintains role clarity between provider (physician/nurse) and receiver of treatment (patient), it also implies and positions the patient as a passive recipient of treatment. The term “patients” within the context of the MHA reinforces this notion of passivity and reliance; as noted, patients are

“received, detained or taken charge of” for the provision of treatment (Nair, Tremor, & Harris, 2000). The term patient furthermore connotes a unilateral relationship between the patient and healthcare practitioner, with the patient receiving instruction and treatment from a physician and/or nurse who is informed and maintains expert psychiatric and medical knowledge (Nair, Treloar, & Harris, 2000).

Persons in need of involuntary treatment are constructed as vulnerable and dangerous through criteria on Form 4 and Form 6. In order to be certified, the person must require “care, supervision and control” in a hospital setting in order to prevent their “substantial mental or physical deterioration” or to protect themselves from self-harm and/or for the protection of others (MHA, 1996, s. 2; Ministry of Health, 2005). This associates people experiencing MHIs in need of involuntary treatment as unpredictable, irrational, susceptible to harm and/or violence, and incapable of caring for themselves. The Guide adds that without involuntary treatment “these seriously mentally ill people would continue to suffer, causing significant disruption and harm to their lives and the lives of others” (Ministry of Health, 2005, p. 1).

This positions persons in need of involuntary treatment as liabilities in need of intervention by the state. Rather than being applied to all members of society who pose potential of harm to self or others, the MHA “creates a special class of citizen by targeting people with mental illnesses” (Livingston, 2013, p. 14). As previously mentioned, people experiencing social and economic marginalization are also more likely to experience disproportionate levels of certification and involuntary treatment. This includes people living in remote areas without access to voluntary mental health treatment, people with cognitive disabilities, older adults, racialized and Indigenous people, women, people with low incomes, people identifying as

LGBTQ2S, people with physical disabilities, as well as people with substance use issues (LCO, 2017; Livingston, 2013).

The MHA established safeguards intended to protect patient rights, ensuring “the appropriate and lawful application of involuntary admittance and treatment” (Ministry of Health, 2005, p. 1). These rights are outlined on *Form 13: Notification to Involuntary Patient Rights under the MHA*, which include: the right to know the location and name of the facility, reason for involuntary admission, to contact a lawyer, to regular review by a physician - to assess whether ongoing certification is necessary, request for a second medical opinion regarding diagnosis including proposed treatment, access to review panels, judicial review, along with the option to appeal the involuntary detainment through court (MHA, 1996; Ministry of Health, 2005). Rights notification is provided by the physician or nurse upon admission, transfer, a change in treatment status (from voluntary to involuntary), and prior to completion of renewal certificates (Form 6).

The patient must be verbally informed and provided a written notification of their rights. According to the Guide, Form 13 has “been rewritten as plain language, consumer friendly documents to facilitate explaining to patients their rights under the Act” (Ministry of Health, 2005, p. 1). If the patient “refuses to sign”, the Guide suggests for the nurse or other healthcare practitioner to make note of this directly on the form, however this notification is not mandatory and furthermore not included in the Act (Ministry of Health, 2005). If the patient “does not, or appears not to, understand the rights information upon admission, it must be repeated as soon as the person is capable of understanding the content therein and another copy of Form 13” provided (MHA, 1996, p. 19). It is not identified how or when a healthcare practitioner is to determine or reassess a patient’s capacity to understand Form 13, rather individual interpretation of ‘insight’ and ‘capacity’ are relied upon. According to the Guide (Ministry of Health, 2005),

assistance should be provided by the facility “for people who may not understand the rights information because English is their second language or because of other communication challenges, such as a hearing deficiency” (p. 41).

Timing of rights notification is not specified within the Act or Guide, rather general phrases such as “promptly upon admission” or “before renewal” are provided allowing rights notification to be up to a nurses’ discretion (Ministry of Health, 2005, p. 41). According to a report prepared for the Ministry of Health (R.A. MA Latest & Associates Ltd., 2000), of those experiencing involuntary treatment, only about 53% reported knowing their rights, 31% reported being notified of their rights by nurses or physicians upon admission, and the remaining 16% who were aware of their rights reported learning about their rights through sources other than healthcare practitioners, such as advocates or lawyers (Johnston, 2017). A patient satisfaction survey carried out by the Ministry of Health in 2010, also found that only 57% patients admitted under the MHA reported having their rights explained in a way they could understand them⁴⁹ (as cited in Johnston, 2017).

There is an overall lack of training and education for nurses and physicians regarding patient rights and how to implement the rights provided (Kirwan, 2016). Healthcare practitioners also experience a lack of time and support in hospital settings to engage effectively and ensure the patient’s comprehension of rights (Johnston, 2017; Kirwan, 2016). Johnston (2017) found an overall low compliance of healthcare practitioners providing involuntary patients with their rights in BC; when patients were notified of their rights, concerns still arose regarding the quality of rights information provided (Johnston, 2017). There is also “no administrative body that

⁴⁹ Original source publicly unavailable.

detainees can complain to if there has been a failure in the provision of rights information” or quality of rights provision (Johnston, 2017, p. 59).

Having nurses and physicians who are actively involved in providing involuntary treatment notify and explain rights to their patients is also a conflict of interest. Since nurses and physicians “are responsible for gaining a detainee’s cooperation” under involuntary treatment, investing time to ensure “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 healthcare practitioner (Johnston, 2017, p. 62). Due to the unequal and conflicting relationship between provider and patient, patients “cannot freely ask questions about their rights”, rather “questions about their legal rights or the decision to request a review panel [can be interpreted] as an indication that they lack insight into their mental illness” (Johnston, 2017, p. 67-68). This includes patient’s concerns regarding medication or treatment side effects; involuntary patient’s concerns are often “discredited, not legitimized and subsequently re-interpreted in a psychiatric lexicon”⁵⁰ (Nash, 2013, p. 23). Patients receiving involuntary treatment under the MHA are provided some tools to protect their rights, however are simultaneously forbidden to confront inequitable practices due to assumed incapacity and lack of insight. In comparison, other Canadian jurisdictions “recognize [the]... 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” (Johnston, 2017, p. 68).

⁵⁰ Involuntary patients have a right to know the medications they are being prescribed, including any potential side effects. However, in practice, ‘psychotropic’ medications such as quetiapine are often explained to patients as helping to induce sleep. Although this medication promotes drowsiness, the primary intention of administering the medication may actually be for the treatment of psychiatric symptoms – such as auditory hallucinations or anhedonia. Therefore, rather than disclosing the primary purpose of the medication the healthcare practitioner can shield themselves from potential confrontation or resistance.

The rights afforded to patients under involuntary treatment are limited and confronted with various obstacles. For example, review panels take up to 14 days to occur, with determinations made within 48 hours upon completion of the review panel (Ministry of Health, 2005). This can extend a patient's involuntary status for up to 16 days even if they are determined to be inappropriate for involuntary treatment. Requests for review panel can only occur "after the second Medical Certificate is completed and following each renewal of the certificates" – between one to six months' time (Ministry of Health, 2005, p. 45). It was not until 2016 that it became mandatory to provide legal representation to patients for review panels; up until that point, if a lawyer or advocate was unavailable, the patient would be expected to represent themselves or adjourn their review panel to a later date⁵¹ (Johnston, 2017). Similar to review panels, requests for second medical opinion can only occur once every renewal period (Ministry of Health, 2005). While second medical opinions provide an opportunity to review and potentially alter the patient's diagnosis, treatment plan or involuntary status, the "secondary physician is unlikely to refute the admission and treatment plan of the initial physician" (Groves, 2011, p. 3).

The majority of patients furthermore do not engage with the application to court option (Section 33 of the Act) because it is costly, time consuming, and if unsuccessful, the patient risks a "court cost award[ed] against them" (Bradley, Marshall, & Gath, 1995; Johnston, 2017, p. 157). According to Johnston (2017), "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" (p. 154). The MHA is furthermore "silent on topics such as ...

⁵¹ This change occurred due to a constitutional challenge to the Supreme Court of BC in relation to case *Z.B. v British Columbia (Attorney General)*.

rights of communication and access to information ..., including access to a telephone, access to the internet or a cell phone, and in person access to a legal advocate or lawyer” (Johnston, 2017, p. 59-60). Such omissions and lack of clarification allow for denial and withholding of access to certain rights without cause (Groves, 2011; Johnston, 2017). Although the MHA ensures access to review panels, free legal representation, second medical opinions, court applications, and judicial reviews to challenge involuntary status, patients under BC’s MHA “have fewer and weaker rights ... than they do under most other MHAs in Canada” (Groves, 2011, p. 4).

Form 15: Nomination of Near Relative is the closest that the MHA comes to providing substitute decision makers, representatives, and/or advanced directives during the involuntary treatment process (MHA, 1996). Form 15 allows for the nominee to be advised of discharge from hospital, receiving a completed *Form 17: Notification to Near Relative (Discharge of Involuntary Patient)*. If the patient does not nominate anyone, the facility notifies “any near relative” they deem appropriate (Ministry of Health, 2005, p. 42). However, “in addition to the person selected by the patient, the director may, if the director considers it to be in the best interests of the patient or the safety of others, send the notice to any other near relative” (p. 43). Guidance and/or criteria for selecting a ‘near relative’ is not provided in the Act or Guide. It is further not required for physicians or nurses to engage in ongoing communication with family through the involuntary treatment process, although it is “recommended... when possible and appropriate” (p. 26). Rather, it is up to the healthcare practitioner’s discretion whether to refer to family regarding the patient’s history of MHI, previous treatments – effectiveness and outcomes, treatment approach and plan, or current status. This maintains a paternalistic relationship as physicians and nurses continue to decide on the behalf of patients, including their families, what

is deemed in the ‘best interests’ of the patient and course of treatment – positioning patients as passive receivers of care and treatment.

The rights provided for patients experiencing involuntary treatment under the MHA are constructed primarily to assist and serve those enforcing the legislation rather than the patients affected by it. The patients are afforded little to no autonomy or capacity to challenge the involuntary treatment process, and minimal rights to obtain accountability for experiences of unethical treatment by healthcare practitioners or police. According to the Law Students’ Legal Advice Manual (2017), mental health legislation is typically over-inclusive, and “therefore impairs the rights of mentally ill persons in areas where they might have the mental capacity to act for themselves” (Law Students’ Legal Advice Manual, 2017, p. 7). Ultimately, the rights afforded to patients and minimal opportunities provided to challenge involuntary treatment does nothing “to address the systemic issues” of rights abuses and mistreatment occurring in psychiatric units or in the community setting across BC (Johnston, 2017, p. 171).

The overall lack of patient inclusion is paternalistic, maintaining assumptions that people experiencing involuntary treatment are incapable of engaging in treatment decisions or planning. Assuming incapacity helps to justify the delegitimization of concerns and objections raised by involuntary patients; this process of silencing and othering sits at the foundations of coercive treatment practices to ensure and maintain compliance for the ‘best interest’ of the patient.

Summary

The MHA and Guide to the MHA position physicians with all decision making authority; physicians initiate and maintain protection by deciding the course and type of treatment, order for coercive and disciplinary measures to enforce compliance – such as chemical restraints or seclusion rooms, as well as determine the length of detention in hospital and on Extended Leave

– including the conditions that must be met while on Extended Leave. Police officers are positioned to enforce protection in the community, through apprehension, detainment and transport of patients to hospital. Police ensure the interruption and containment of ‘socially disruptive’, ‘abnormal’ or ‘unsafe’ behaviour. Nurses are positioned to implement and enact protection through the enforcement of the physician’s treatment plan, engaging in the everyday “care, supervision and control” of involuntary patients (MHA, 1996, s. 22). This includes enforcing the consumption of psychotropic medications and PRN⁵² medications, implementation of coercive treatment measures – physical restraints or use of seclusion rooms, and the surveilling of symptoms, behaviors and compliance to treatment. Physicians, police officers and nurses maintain positions of power where they are able to determine actions on behalf of and in the ‘best interest’ of the patient, while protected from liability in relation to performing any functions within the MHA.

The Act and Guide position patients as risk-laden objects that are too vulnerable or too dangerous to care for themselves and therefore in need of protection by the state through involuntary treatment. Within the Act and Guide the presence of a “mental disorder” presumes patients as pathological (unpredictable, irrational, susceptible to harm and/or violence) and incapable of caring for themselves or “giving, refusing, or revoking consent to psychiatric treatment” (Johnston, 2017, p. 76). Due to the lack of incorporation and collaboration regarding the patients’ preferences, agency or rights throughout the Act and Guide, patients are furthermore positioned as passive receivers of care who lack the capacity to engage in treatment decision making or planning. Deciding on behalf of the patient without due capacity assessment

⁵² PRN is an abbreviation for ‘pro re nata’ meaning ‘as necessary’; in psychiatry, PRNs are typically used for medication orders (to help alleviate, contain or control anxiety, agitation and insomnia – via oral and injectable administration) and practices such as the use of restraints and seclusion rooms.

or an obligation to obtain consent further reinforces an identity of dependence and assumed incompetence. References to engaging or consulting the patient throughout the Act and Guide are virtually absent, likely due to assumptions relating MHIs with incompetence, including the maintenance of the current social order; involuntary and coercive treatment interventions create and maintain power relations that seek to ensure the service-user “regulates their own conduct in accordance with the norms promoted by psychiatry and mental health nursing” (Roberts, 2005, p. 36). Assumed incapacity and lack of insight furthermore act to justify the privation of meaningful and available avenues for challenging involuntary status or confronting experiences of unethical treatment.

Chapter 5: Implications of the Discourse of Protection

Protection is enacted by healthcare practitioners and police through the implementation of various MHA forms and is associated with reducing the risk of harm for individuals experiencing MHIs and for society at large. The discourse of protection - and actions related to enforcing protection, justify and normalize involuntary and coercive treatment measures (such as overriding consent, enforcing treatment, controlling and surveilling behavior) by uncritically aligning “mental disorders” with incompetence and incapacity. Public interests of ‘safety’ are amplified by prevailing discourses associating people with MHIs with vulnerability, incapacity and dangerousness/violence (McWade, 2016).

Since patients are deemed mentally incapable and dysfunctional, healthcare practitioners and police must act on behalf of their best interests. Although “best interest” is only used in the Guide⁵³, this linguistic expression of protection underlies the entirety of the Act and Guide through assumed vulnerability and incompetence of the patient. Acting in the ‘best interest’ of the patient “paternalistically displac[es]... the actual or presumed views of the patient” (Gurnham, 2008, p. 274). Such assumptions of helplessness and potential risk are potent forms of oppression that permit and justify “the removal of decision-making power” (Spagnuolo & Earle, 2017, para. 4). Failing to recognize personal autonomy and the capacity for self-determination violates the right of personal liberty, often leading to negative outcomes such as the use of coercive treatment practices to enforce compliance to treatment (Johnston, 2017). Assuming incapacity also helps justify the delegitimization of concerns and objections raised by

⁵³ On eight separate occasions referring to discharge notification to a secondary near relative, release of information, and shortening the time period allowing a patient to request a review panel (Ministry of Health, 2005).

involuntary patients, further normalizing the use of coercive treatment practices and lack of meaningful patient engagement and rights.

Although the MHA's stated intentions are to reduce harm and provide care for people experiencing MHIs, the Act and Guide sustain a significant contradiction; the manner of providing protection through involuntary treatment under the Act actually violates the safety and consent of people who are deemed 'the most vulnerable' in society. In addition, the MHA disproportionately affects people experiencing numerous and intersecting forms of structural violence in its application. Therefore, if the Act and Guide are not protecting the patients, whose interests and needs are being served and protected?

Involuntary treatment under the MHA is constructed to primarily serve and protect those enforcing the legislation, versus the patients affected by it. Healthcare practitioners are centered throughout the Act and Guide. Consultation and collaboration with patients and their families within the MHA are practically absent and further not obligated, in relation to actions involving consent processes, treatment planning, Extended Leave, and rights notification. All decision making authority remains with the physician, nurse and police officer. Healthcare practitioners and police are further protected from liability in relation to performing any functions within the MHA. Opportunities to assess and ensure the ethical and appropriate application of involuntary treatment under the MHA exist, however requirements on policy levels are severely limited, if not entirely absent. The Act and Guide utilize and depend heavily upon an official, bureaucratic, biomedical discourse in an attempt to construct it as neutral and objective, obscuring the power of those constructing it, and entrenching existing power relations.

The lack of consent, accountability and patient engagement affords healthcare practitioners near unilateral power over involuntary patients. The MHA poses few avenues or opportunities to challenge certification, involuntary status or involuntary treatment practices. While many nurses and physicians may resist aspects of the MHA (for example, through the promotion of shared decision making and consent), the amount of unconstrained power the MHA affords, alongside the overall lack of accountability and oversight, is problematic and allows increased opportunity for unethical and excessive application of involuntary and coercive treatment measures.

Involuntary treatment also serves public interests of ‘safety’, including the regulation and control of ‘socially disruptive behavior’. Although evidence shows that MHIs are a poor predictor of violence or crime (Canadian Mental Health Association, 2011), lack of understanding and sensationalized stories by the media have exacerbated stigma and discrimination, depicting people with MHIs as inherently violent, unpredictable, and impulsive – and also criminogenic. People living with MHIs are in fact no more likely than the general population to engage in violent behaviour⁵⁴ (Canadian Mental Health Association, 2011). Public interests related to ‘safety’ are therefore based on stereotypes and misconceptions that validate involuntary and coercive treatment practices, such as police intervention and detainment. This notion of protecting public safety concurrently reinforces the stereotypes and misconceptions it relies upon. While police intervention provides feelings of security and safety for some, the MHA has and continues to contribute to a policing approach that disproportionately affects people living with MHIs through detention, incarceration, involuntary treatment, violence and potential death.

⁵⁴ People experiencing MHIs, especially women, have been found to be two to four times more likely to experience violence (such as robbery, physical or sexual assault) in comparison to the general population (Statistics Canada, 2018).

While involuntary treatment is used to prevent deterioration and/or harm of individuals experiencing MHIs, the MHA often acts as a reactionary measure to deal with systemic shortfalls on an individual basis. For example, the MHA maintains biomedical and psychiatric approaches for treating and diagnosing MHIs, locating problems within individuals without considering their relation and/or social causation (British Psychological Society, 2011). Psychiatric and biomedical discourses exclude social and structural factors that influence MHIs (such as poverty, homelessness, ableism, colonialism, discrimination, criminalization of substance use, lack of evidence-based and appropriate services), and are therefore reductionist, reactionary and individualistic. These discourses divert attention away from addressing social and structural inequities, primarily focusing on individually oriented problems and solutions – emphasizing diagnosis and pharmaceutical treatment versus poverty reduction and access to safe and secure housing. The biomedical and psychiatric approach to ‘treating’ MHIs alone has proven ineffective and detrimental to patients, often promoting repeat involuntary committals, coercive treatment measures and under-treated MHIs (Lake & Turner, 2017).

The manner in which the Act and Guide construct protection and position patients highlights how discourse operates more broadly to support practices of governing human behaviour in contemporary society. Public perceptions, including the manner in which we systemically ‘treat’ people with MHIs remains heavily influenced by the social and historical context from which conceptualizations of MHIs arose and continue to evolve from. The Act and Guide operate to incite problematic power relations against people with MHIs that are justified through discourses of discrimination and othering - relying on ableism, colonialism, gendered assumptions and classism. Rather than addressing or reducing structural inequalities that are “avoidable, ... socially produced and structurally driven”, the MHA legitimizes and formalizes

inequitable and coercive treatment through discourse, commonly disadvantaging those already experiencing social and economic marginalization (Boyd & Kerr, 2016; Ingram et al., 2013, p. 8). Without acknowledging or critically analyzing the socio-historic influences towards contemporary and evolving conceptualizations of MHIs, dominant approaches to mental health treatment will continue to rely upon and reinforce physical, attitudinal, professional, and systemic barriers to forms of treatment that are non-coercive, social and equitable in nature (Shier & Sinclair, 2000).

Implications for Nursing Practice

Psychiatric and biomedical discourses have been adopted within mental health practice as the basis of practice, especially within acute care settings (Crowe, 2000). According to Goulter, Kavanagh and Gardner (2015), “the role of the mental health nurse has evolved to extend the treatment options of medical science rather than engage in the recovery processes that both literature and health policy indicate as the modern framework”, such as: encouraging service-user engagement, promotion of personal safety, assistance with crises, and confidentiality (p. 450). The psychiatric and biomedical approach to mental health nursing encourages task-oriented and impersonal engagement, primarily focused on diagnosis, pharmaceutical and medical interventions (Goulter, Kavanagh, & Gardner, 2015). For example, contemporary mental health nursing care in acute settings largely consists of “dispensing medication, controlling the behaviour associated with mental distress until the medication takes effect and helping the individual to adapt their life to the inevitable disability of a biochemical dysfunction” (Crowe & Alavi, 1999, p. 31; Goulter, Kavanagh, & Gardner, 2015).

Psychiatric discourse furthermore positions healthcare practitioners as ‘experts’ maintaining specialized knowledge and medical authority, while positioning patients as

dependent and passive recipients of advice and treatment (Roberts, 2005). According to Feuston and Piper (2018), this “disempowers individuals with mental illnesses and positions them, and their lack of expertise and authority, in contrast to healthcare providers and caretakers” (para. 11). The primary role of the mental health nurse has depended on psychiatric and biomedical discourses affecting service-user engagement and approaches to mental health treatment.

Mental health nurses are positioned to work with competing models of care since broad conceptualizations of mental health, and systems geared towards treating MHIs, maintain biomedical and psychiatric orientations to treatment - being individualistic and paternalistic. Conversely, the ethical principles nurses are bound to (such as: beneficence, non-maleficence, justice, confidentiality, consent and health promotion)⁵⁵ including the biopsychosocial model that is collectively taught in nursing programs are centered on social justice and are holistic in approach (CNA, 2017).

Implementation of involuntary and coercive treatment measures formalized under the MHA also position nurses in contradictory ways - between professional obligations under the Act and ethical nursing practice (Canadian Nursing Association, 2017). To implement the MHA, nurses must take away a patient’s “freedom, their bodily integrity, their right to make decisions, and in many circumstances, their voice” (Johnston, 2017, p. 171). This directly conflicts with the ethics promoted for and by nurses such as “providing safe, compassionate, competent and ethical care” while “promoting justice” (CNA, 2017, p. 8-15). The MHA further infringes upon various aspects of *The Charter of Rights and Freedoms* (1982), including “sections 7 (the right to liberty), 9 (the right to protection against arbitrary detention)[,]... 15 (the

⁵⁵ According to the Canadian Nursing Association (2017), the Code of Ethics for Registered Nurses “is intended for nurses in all contexts and domains of nursing practice”, including mental health practice (p. 2).

equality provision) ... [including] s12, which concerns cruel and unusual punishment” (Law Students’ Legal Advice Manual, 2017, p. 9). Removing people’s rights through involuntary treatment, and using coercive practices to ensure compliance is morally distressing for nurses and traumatic for patients (Christodoulou-Fella, Middleton, Papathanassoglou, & Karanikola, 2017).

Chapter 6: Conclusions and Recommendations

The structuring of knowledge and practice that underlie the Act and Guide are based on the socio-historical context from which conceptualizations of MHIs arose. The findings from this CDA can inform an understanding of the socio-historical discourses influencing and impacting mental health legislation and nursing practice in BC. A CDA of the Act and Guide has provided insight into how discourses operate to incite power relations in discriminatory and abusive ways that maintain social inequity for people with MHIs in contemporary mental health practice in BC. In so doing, this analysis exposed how the positioning of patients and the ‘need for protection’ as per the Act and Guide overwhelmingly remove the rights and freedoms of people with MHIs while promoting involuntary and coercive treatment practices to enforce patient compliance.

Through the discourse of protection, these texts construct and position patients as incompetent, vulnerable, dangerous, un-trustworthy, dysfunctional and irrational. Patients are identified as risk-laden objects and social liabilities in need of state intervention, while protectionism serves to uphold what is seemingly valued to protect the best interest of the individual and society at large. This positioning reinforces and justifies the perceived need for protection of the patient and public through involuntary and coercive treatment practices to ensure patient compliance. Such positioning further normalizes the lack of meaningful patient engagement and opportunities provided to challenge involuntary and coercive treatment practices throughout the Act and Guide. The Act and Guide further enlist broader discourses based on stereotypes and misconceptions of people experiencing MHIs to justify the problematic power relations and coercive treatment practices therein. Involuntary and coercive practices are

formalized by the MHA which reinforce and sustain archaic approaches to psychiatric treatment commonly disadvantage those already experiencing social and economic marginalization.

The Act and Guide serve to not only maintain dominant social relationships with physicians, nurses and police, these texts extend support towards practices of governing human behaviour in contemporary society more broadly. The Act and Guide reinforce a social order that dictates what is ‘normal’ and therefore acceptable behaviour, versus ‘abnormal’ and ‘dysfunctional’ behaviour in need of correction. The social order enforced by these texts rely on broader social values and norms of productivity, self-sufficiency, individualism, ability and ‘rationality’ (Crowe, 2000). Such social values enforce a social order tying an individual’s value with their productivity and profit potential – constructing those identified as non-productive as disposable. The current social order requires such ableist constructs and marginalization to sustain the problematic power relations and coercive psychiatric treatment practices as formalized by the MHA - similar to how such harmful constructs have legitimized and formalized intrusive and nonconsensual psychiatric interventions throughout history. Disrupting the current social order would challenge the manner in which MHIs are constructed, how mental health treatment and protection is enforced, as well as the broader value systems of productivity and profit potential of individuals. Disruption of the current social order would further necessitate the confrontation of structural inequities being reproduced for patients – and for people with MHIs more broadly.

Rather than alleviating or addressing social and structural factors contributing to poor mental health, the Act and Guide are used as reactive tools that aid in the maintenance of current systems, functioning on the ‘default status’ of ability, productivity, whiteness, masculinity, heteronormativity, financial stability, and colonization. The Act and Guide therefore serve the

interests and needs of healthcare practitioners, police and the public to enforce behavioural control, rather than the patients affected by the legislation.

Legislation and mental health practice must be reconstructed to comply with *The Charter of Rights and Freedoms* (1982) and the *United Nations Convention on the Rights of Persons with Disabilities* (2006), balancing the “autonomy and liberty of the individual” with the need for psychiatric treatment (Government of Canada, 2013; Grey, Weller, & McSherry, 2010; Rasmussen & Lewis, 2007; Schizophrenia Society of Ontario, 2013, p. 7). Recommendations purposed by CLAS BC should also be reviewed and implemented, such as: reviewing and amending the deemed consent model to promote consent rights; increased oversight and accountability of the MHA process – including standardization for use of seclusion and restraints; ensuring the proper education and training of healthcare practitioners and police – especially in relation to patient rights; periodic legal review of detentions; as well as removing “requirements for involuntary status under the Mental Health Act as a prerequisite for receiving mental health care and services”⁵⁶ (Johnston, 2017, p. 175).

Similar to Ontario, the BC MHA should assess for a patient’s capacity to consent prior to assuming incompetence, separating involuntary admission from involuntary psychiatric treatment (Johnston, 2017; Schizophrenia Society of Ontario, 2013). The MHA should further be reconstructed to incorporate a patient-centered approach, actively involving patients and their families to promote supported decision-making, relying on the input from those who have experienced involuntary treatment regarding type and course of treatment (Gooding, 2013). Incorporation of a secondary decision maker and advanced directives will further facilitate and

⁵⁶ For an in-depth overview of the amendments necessary for the MHA, please refer to the work of Laura Johnston (2017).

reinforce the incorporation of family and shared-decision making (Schizophrenia Society of Ontario, 2013). Although briefly mentioned in the Guide, there is no explicit reference for involuntary treatment in the Act itself needing to be the least restrictive option possible (Grey, Weller, & McSherry, 2010). This should be emphasized in the MHA, ensuring the least restrictive care is provided.

The reconstruction of the Act and Guide must also include a critical review and analysis of the various discourses and stereotypes relied upon that maintain problematic power relations of healthcare practitioners and police, violating patient rights and safety. Discourses of equity provide a counter to current health care practices and structures that rely on harmful narratives and discourses based on deficit, vulnerability, dangerousness, and incapacity. An equity orientation can also be applied to address varying forms of marginalization experienced by people with MHIs, challenging the dominant socio-historic discourses in mental health practice and legislation (such as biomedicalism, psychiatry, ableism, colonialism and neoliberalism) (Canadian Mental Health Association, 2014).

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 securing housing and poverty reduction (Karban, 2016). An equity-oriented approach avoids dichotomous and individualistic thinking common in discourses surrounding mental health (Karban, 2016). The discourse of equity promotes the provision of non-coercive and anti-oppressive mental health treatment, offering more nuanced understandings of mental health and MHIs. Discourses of equity can be

incorporated into mental health practice through implementation of equity-oriented care which includes practice grounded in harm reduction, culturally safe care and trauma and violence informed care (Browne, Varcoe, Ford-Gilboe, & Wathen, 2015).

Since nurses maintain the ethical obligation to promote and ensure equitable care for all, it is important for nurses to be aware of the discourses underlying and being enacted through the MHA, including how such discourses influence and affect nursing practice (CNA, 2017). Nurses enacting involuntary and coercive treatment practices must work against their designation's code of ethics (Canadian Nursing Association, 2017). If mental health treatment is to give primacy to equitable care, current practices must reduce reliance and use of involuntary and coercive treatment practices. In order to provide a more social and equitable approach to mental health and mental health treatment, we must look beyond the conventional and binary discourses presented through the biomedical and psychiatric models currently offered.

Nurses are ideally positioned to advocate for the incorporation and implementation of equity-oriented care into nursing programs, practice settings and broader health systems. As healthcare practitioners, nurses can assist patients with the navigation of complex and often inaccessible services, policies and legislation. Nurses can also promote shared decision-making, engaging in involuntary and coercive treatment in exceptional circumstances only. Nurses can furthermore engage in critical reflexivity, challenging discriminatory views while advocating for more equitable treatment for individuals with MHIs in their workplace (Naylor, Das, Ross, Honeyman, Thompson, & Gilbert, 2016). Challenging and resisting harmful discourses, such as that of protection and the ableist positioning of patients employed by the Act and Guide, will help to further shift the manner in which people with MHIs are portrayed in legislation - achieving improvements in direct care practices and social stigma.

Health policy action and amendments to legislation alone however will not tackle the structural inequity experienced by mental health populations; nurses must therefore call attention to and disrupt the social inequities and harmful value systems impacting people with MHIs more broadly, engaging in social justice and advocacy regarding the social determinants of health (Livingston, 2013). Engaging with issues on a structural level provides nurses the opportunity to influence the course of health policy processes, legislation formulation and resource allocation decisions. In order to create more accessible, equitable and prevention oriented health systems and societies for people experiencing MHIs, nurses must work collaboratively and inter-professionally, maintaining open dialogue with patients, families, stake-holders, politicians and policy makers. Foregrounding the patient experience is central to understanding and providing a more equitable alternative to mental health treatment, promoting practices that are influenced by and for the people they are intended to serve. Nurses must furthermore support and advance the critical education of nursing students, which includes the analysis of the nurse's role in mental health care, impacts of ableism in involuntary psychiatric treatment and ways to mitigate coercive and unethical practices therein. Such curriculum should be promoted to all healthcare practitioners who interface with the MHA, achieving improvements in social stigma and direct care practices.

Future Research

To date, very limited research exists regarding ways nurses embody or resist involuntary and coercive psychiatric treatment practices. Future research should seek to uncover how nurses, and healthcare practitioners more broadly, go about resisting or normalizing involuntary and coercive psychiatric treatment practices. Future research should also seek to explore ways nurses challenge and alter harmful discourses towards people with MHIs in practice settings. The

implementation of MHA should also be studied to determine the effectiveness of voluntary and involuntary treatment approaches. Completing a global scan that analyzes and compares the most current and least harmful approaches to involuntary treatment will generate knowledge and evidence to drive policy and legislative alternatives to the current MHA in BC.

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