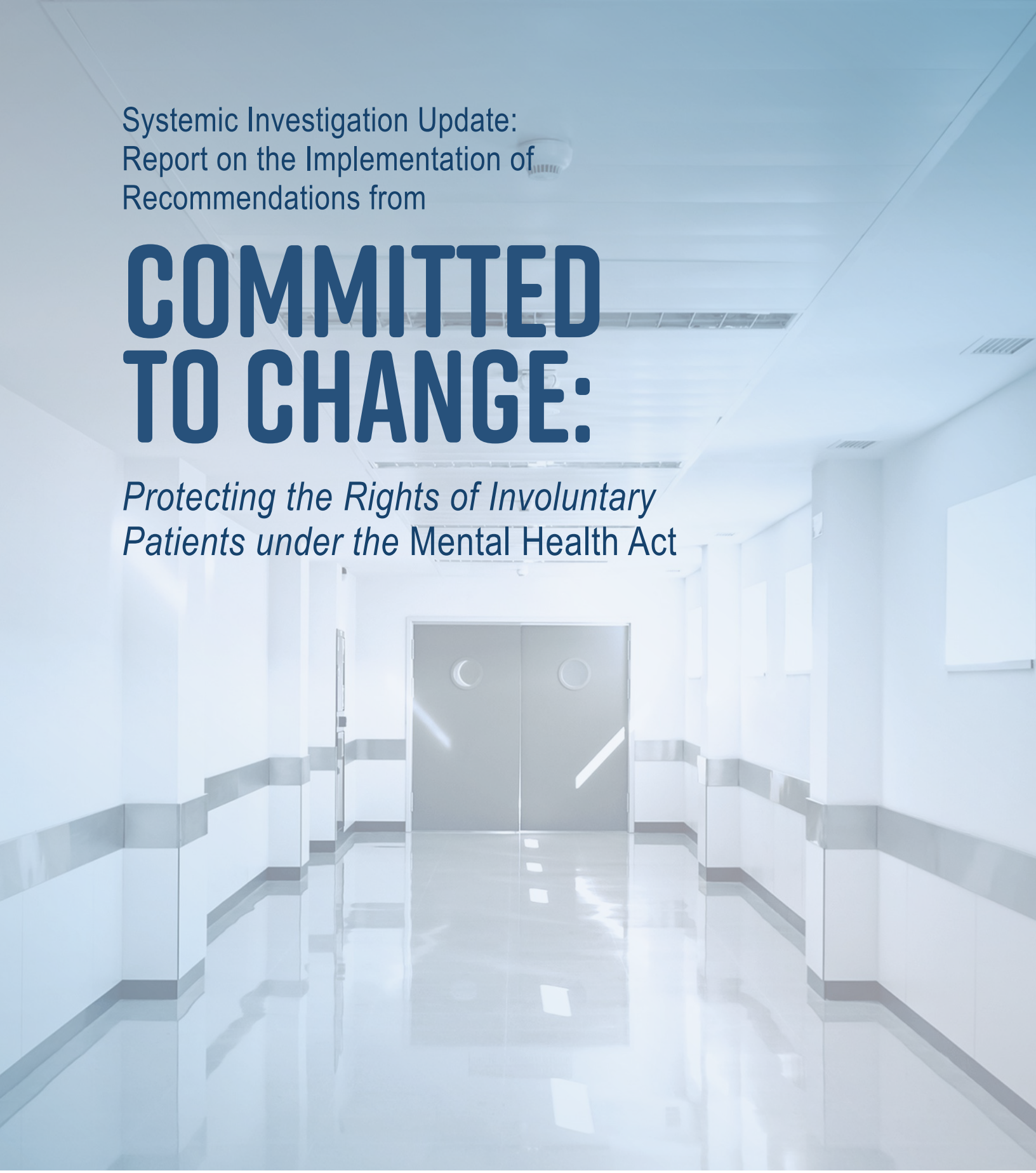
Systemic Investigation Update:
Report on the Implementation of
Recommendations from

COMMITTED TO CHANGE:

Protecting the Rights of Involuntary Patients under the Mental Health Act



OMBUDSPERSON
BRITISH COLUMBIA

Systemic Investigation Update
July 2022

INTRODUCTION

One of the key ways in which the Office of the Ombudsperson can effect change in the fair administration of government programs is by making recommendations. Our recommendations result from investigative findings of unfairness. In other words, when our investigation highlights a problem in fair administration, our recommendations aim to fix that problem. Our recommendations may involve individual remedies or systemic change, and often contain timelines by which we expect an authority to have made the change.

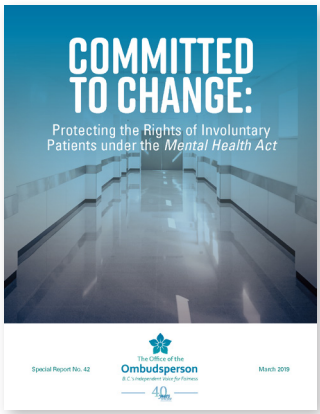
Once a report is released publicly, we begin monitoring the implementation of the recommendations by the authority. We collect information from the authority about the steps they have taken to implement the recommendations. We expect the authority to provide us with specific, relevant and verifiable information about its implementation steps – a general commitment to act is not sufficient. We then assess this information to determine whether, in our view, the recommendation is fully implemented. While some recommendations may be implemented quickly, others may be implemented over time. As part of this monitoring commitment, we issue periodic updates on specific reports and their recommendations. In this monitoring report, we identify the stage of implementation for each recommendation as fully implemented, implementation ongoing, and no progress.

COMMITTED TO CHANGE REPORT AND RECOMMENDATIONS

We released *Committed to Change: Protecting the Rights of Involuntary Patients under the* Mental Health Act in March 2019.[1] The report was the product of a comprehensive investigation into involuntary admissions under the *Mental Health Act.*[2] We investigated whether mental health facilities[3] were complying with the procedural requirements for involuntary admissions in the *Mental Health Act*, namely the completion of prescribed forms. These include:

- Forms 4 and 6 (authorize and set out reasons for initial admission and detention and any subsequent renewals)
- Form 5 (authorization for and consent to psychiatric treatment)
- Form 13 (notice of and information about patient rights)
- Forms 15 and 16 (designation and notification of near relative)

The report's findings were based on a review of admission records of every involuntary admission in British Columbia in June 2017. A detailed analysis of mandatory admission forms found that across the province, all of the required forms were completed in only 28 per cent of involuntary patient admissions. A number of directors of designated facilities admitted and detained people involuntarily without adequate information and reasons to demonstrate how the patient met the criteria for admission. There was no consent for treatment form in 24 per cent of patient admissions across all health authorities, with wide variation among hospitals. There was no rights advice form – which advises patients of their legal rights, including how to get legal advice and challenge their detention – for more than half of the involuntary patients. We found that the Ministry of Health and the health authorities acted unreasonably in failing to adequately monitor, audit and address designated facilities' compliance with the involuntary admission procedures under the *Mental Health Act*.



[1] The original report, *Committed to Change: Protecting the Rights of Involuntary Patients under the* Mental Health Act, is available on our website at https://bcombudsperson.ca/investigative_report/committed-to-change-protecting-the-rights-of-involuntary-patients-under-the-mental-health-act//.

[2] *Mental Health Act*, R.S.B.C. 1996, c. 288.

[3] *The Mental Health Act* allows the Minister of Health to designate facilities that can involuntarily admit patients under the Act. Designated facilities are classified as Schedule A, B or C facilities, depending on their role. Many of the admissions to Schedule A facilities are transfers from other facilities. A list of designated facilities is available at https://www2.gov.bc.ca/assets/gov/health/managing-your-health/mental-health-substance-use/facilities-designated-mental-health-act.pdf.

The report made 24 recommendations focusing on three key areas:

- *Increasing oversight and accountability* by conducting regular compliance audits, setting 100 per cent compliance targets and increasing public reporting about involuntary admissions
- *Training staff and physicians* regarding the necessity of form completion, and developing and codifying standards for compliance with the *Mental Health Act*
- *Developing an independent rights advisor service* that would work in designated facilities in the province and provide advice to patients about the circumstances of their detention and their options if they disagree with the detention or a related decision

All of the recommendations in our report were accepted in principle by government and the health authorities. The recommendations are directed toward the public authority with responsibility in the relevant area, including the Ministry of Health, the Ministry of Mental Health and Addictions, the Ministry of Attorney General and the health authorities. In cases where there are shared responsibilities, we expect the ministries and health authorities to work together as needed to achieve implementation. We have been monitoring the steps taken by government and the health authorities to implement the recommendations since our report's release in 2019.[5]

This monitoring report highlights our analysis of implemented recommendations and the areas where important work remains to be done. It does so while recognizing ongoing challenges to mental health in the province, including the impacts of two public health emergencies, related to opioid use and COVID-19, as well as other important developments in addressing systemic racism in health care, which we discuss further below.

We are encouraged by the fact that government and the health authorities have made substantial progress in developing auditing systems to increase oversight and accountability for form completion and to improve training for staff and physicians since *Committed to Change* was issued. As this report highlights, however, there is significant work ahead to ensure that the systemic issues we identified in those areas in our report, and particularly related to independent rights advice, are fully addressed.

[4] In July 2017, the government established the Ministry of Mental Health and Addictions, which is separate from the Ministry of Health. Our investigation reviewed records from June 2017, but the overlapping and connected responsibilities of the two ministries mean that both now have a role in providing information to the public and in ensuring that health authorities and designated facilities administer the *Mental Health Act* in accordance with the law. The ministries have worked together, along with the health authorities and the Ministry of Attorney General in some instances, toward achieving implementation of the recommendations in *Committed to Change.*

[5] Our office also continues to receive complaints from individuals who have been involuntarily admitted.

THE CURRENT CONTEXT FOR MENTAL HEALTH IN BRITISH COLUMBIA

The assessment provided in this monitoring report occurs within the context of the provincial government's efforts to identify and address a number of ongoing challenges related to mental health, including the mental health impacts of the public health emergencies related to the COVID-19 pandemic and the overdose crisis in the province, and recent extreme weather events. We are also mindful of other recent reports on related systemic issues in mental health, including *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*, an independent review by Mary Ellen Turpel-Lafond, Aki-Kwe, and *Detained: Rights of Children and Youth under the* Mental Health Act by B.C.'s Representative for Children and Youth. In addition, a report from B.C.'s Human Rights Commissioner, *Disaggregated Demographic Data Collection in British Columbia: The Grandmother Perspective*, has suggested new approaches to data collection and use to support the equitable and just delivery of public services, including mental health services.

Public health emergencies

The Ministry of Health's implementation of our recommendations from *Committed to Change* has occurred within broader discussions in the province on mental health, substance use, reconciliation, anti-racism and equity. The original *Committed to Change* report was published in March 2019, one year before the COVID-19 pandemic began in British Columbia. At that time, the provincial health system was already in the midst of a public health emergency first declared in 2016 related to rates of opioid and other drug overdoses in the province.[6] On March 17, 2020, the provincial health officer declared a public health emergency due to COVID-19.[7]

The pandemic has caused fear, worry and concern, particularly among older adults, youth, care providers and people with other health conditions.[8] In terms of public mental health, psychological impacts have included elevated rates of stress or anxiety, loneliness, depression and harmful substance use.[9] The overdose crisis has also worsened during the pandemic.[10] Both public health emergencies have had significant impacts on the public health-care system in B.C. and

[6] Provincial Health Officer Notice (April 14, 2016), https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/covid-19/covid-pho-notice-od-public-health-emergency.pdf

[7] Provincial Health Officer Notice (March 17, 2020), https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/pho-regional-event-notice.pdf

[8] World Health Organization, Regional Office for Europe, "Mental Health and COVID-19," https://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/publications-and-technical-guidance/mental-health-and-covid-19; BC Centre for Disease Control, "Mental Well-Being during COVID-19," http://www.bccdc.ca/health-info/diseases-conditions/covid-19/about-covid-19/mental-well-being-during-covid-19

[9] World Health Organization, "Mental Health and COVID-19"; Statistics Canada, "Survey on COVID-19 and Mental Health, September to December 2020," https://www150.statcan.gc.ca/n1/daily-quotidien/210318/dq210318a-eng.htm; Government of British Columbia, "Overdose Prevention and Response in B.C.," https://www2.gov.bc.ca/gov/content/overdose

[10] Rajan Bola and Eugenia Oviedo-Joekes, "At a Crossroads: The Intersecting Public Health Emergencies of COVID-19 and the Overdose Crisis in BC," *BC Medical Journal* (April 12,2021), https://bcmj.org/blog/crossroads-intersecting-public-health-emergencies-covid-19-and-overdose-crisis-bc

across Canada, including stresses on health-care workers, hospital services, emergency departments and long-term care.[11] In its updates, the government has specifically noted impacts and delays due to the pandemic in its implementation of recommendations from *Committed to Change.*[12]

Systemic discrimination and equity in mental health

In addition, from November 2020 to February 2021, Mary Ellen Turpel-Lafond released several reports based on an independent review of Indigenous-specific discrimination within the B.C. health care system.[13] The review found widespread systemic racism against Indigenous people, including stereotyping, discrimination and prejudice that results in a range of negative impacts and harm.[14] The final report includes examples of negative impacts on patients admitted to hospital under the *Mental Health Act*[15] and calls for better reporting on Indigenous mental health, a more robust pandemic response for Indigenous mental health, and progress on commitments to increase access to culturally safe mental health services.[16]

In January 2021, B.C.'s Representative for Children and Youth, Jennifer Charlesworth, released *Detained: Rights of Children and Youth under the* Mental Health Act. The report builds on previous reports, including *Committed to Change*, by examining the experiences of children and youth admitted under the *Mental Health Act*.[17] It notes an increasing rate of involuntary detention for children and youth under the *Mental Health Act*; it also notes concerns about data collection by the health authorities. Areas of particular concern include the absence of data on the number of Indigenous children admitted under the *Mental Health Act* and the lack of provincial data on the length of time young people are detained.[18] Like *Committed to Change*, the report also identifies the lack of rights advice and advocacy available to patients detained under the *Mental Health Act* and recommends specific consideration of the needs of children and youth who are detained.[19]

[11] Canadian Institute for Health Information, "Overview: COVID-19's Impact on Health Care Systems" (December 9, 2021), https://www.cihi.ca/en/covid-19-resources/impact-of-covid-19-on-canadas-health-care-systems/the-big-picture

[12] Among the health authorities, Fraser Health has indicated that its implementation efforts have been delayed in relation to Recommendations 6, 12 and 13 because of COVID-19 impacts and have not been started for Recommendation 14 because of the COVID-19 pandemic and overdose emergency.

[13] Government of British Columbia, "Addressing Racism: An Independent Investigation into Indigenous-Specific Discrimination in B.C. Health Care," https://engage.gov.bc.ca/addressingracism/

[14] Mary Ellen Turpel-Lafond, *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care* (November 30, 2020), https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf

[15] Turpel-Lafond, *In Plain Sight*, p. 49 (mistaken assessment and temporary detention under the Mental Health Act) and p. 54 (lengthy mental health detention).

[16] Turpel-Lafond, *In Plain Sight*, recommendations 4, 15 and 17.

[17] Representative for Children and Youth, *Detained: Rights of Children and Youth under the* Mental Health Act (January 2021), p. 23, https://rcybc.ca/wp-content/uploads/2021/01/RCY_Detained-Jan2021.FINAL_.pdf

[18] Representative for Children and Youth, "Significant Changes Necessary to Improve the Experiences and Outcomes of Children and Youth Deeply Impacted by the *Mental Health Act*" (news release, January 19, 2021), https://rcybc.ca/wp-content/uploads/2021/01/NR.Detained.Jan_.19.FINAL_.pdf

[19] Recommendation 5 states: "That the Attorney General in partnership with the Ministries of Health and Mental Health and Addictions, ensure that an independent body is notified every time a child or youth is detained under the *Mental Health Act* and that this body is mandated to provide rights advice and advocacy to children and youth. **Independent body to be in place by Dec. 1, 2021**." (Representative for Children and Youth, *Detained*, p. 77.) This is intended to add a specific focus on children and youth to the recommendations related to independent rights advice in *Committed to Change*.

Equity and data collection

Finally, there have been developments in the provincial approach to data collection in order to address systemic discrimination and protect rights, and these developments also intersect with issues of data collection and use in mental health admissions and involuntary treatment. In June 2020, Premier John Horgan asked B.C.'s Human Rights Commissioner to inform the development of a policy initiative for the collection of race-based, Indigenous and other disaggregated data to address systemic racism.[20] The resulting report proposes taking "the grandmother perspective" in disaggregated data collection, a relational and anti-racist approach to the collection and use of socio-demographic data.[21] Building on this work and the recommendations from *In Plain Sight*, on May 2, 2022, the government introduced Bill 24, the *Anti-Racism Data Act*, which enables data collection for the purposes of identifying and eliminating systemic racism and advancing racial equity.[22] In his introductory remarks, the Attorney General noted the essential role of this data collection in modernizing the health care sector, among others.[23] In its *Declaration Act Action Plan (2022 -2027)*, the government has also committed to a number of proposals related to mental health services for Indigenous people and data collection.[24]

[20] British Columbia's Office of the Human Rights Commissioner, *Disaggregated Demographic Data Collection in British Columbia: The Grandmother Perspective* (September 2020), https://bchumanrights.ca/wp-content/uploads/BCOHRC_Sept2020_Disaggregated-Data-Report_FINAL.pdf

[21] The "grandmother perspective" was offered by Gwen Phillips of the Ktunaxa Nation: "First Nations governments are not wanting to operate with the Big Brother mentality that we've all been groomed into believing in relation to what data does to us — it's more like we want to come from the grandmother perspective. We need to know because we care." (Office of the Human Rights Commissioner, *Disaggregated Demographic Data Collection*, p. 8)

[22] Bill 24-2022, https://www.leg.bc.ca/parliamentary-business/legislation-debates-proceedings/42nd-parliament/3rd-session/bills/first-reading/gov24-1. It passed unanimously through the legislative assembly and received royal assent on June 2, 2022.

[23] Hon. David Eby (May 2, 2022), https://www.leg.bc.ca/documents-data/debate-transcripts/42nd-parliament/3rd-session/20220502pm-House-Blues

[24] *Declaration on the Rights of Indigenous Peoples Act Action Plan (2022-2027)*, https://engage.gov.bc.ca/app/uploads/sites/121/2022/03/declaration_act_action_plan.pdf

PROVINCIAL DATA ON INVOLUNTARY ADMISSIONS

Although there is emerging work in the province on anti-racism and data collection, this is not yet reflected in the data provided by the Ministry of Health for this report. However, since *Committed to Change* was published, the ministry has also made several changes to the way it collects and reports data involving patients who are involuntarily admitted. The report provided several figures related to involuntary admissions in the province, based on data from the ministry.[25]

In this report, we have updated the information provided in the original figures, based on the latest data provided by the ministry.[26] However, the changes the government has made in data collection mean that previously reported data from the *Committed to Change* report (data from 2005/06 to 2016/17) cannot be directly compared with current data presented in the figures below. In addition, two important caveats must be noted.

First, because of changes in reporting by the ministry for the 2018/19 and 2019/20 fiscal years, data that distinguishes between voluntary and involuntary admissions is not available for these two fiscal years. Accordingly, when we use a longitudinal figure, such as Figures 1a and 1b, we have indicated this data gap with a blank space, and we have provided the total number of patients (voluntary and involuntary data is combined for these years) next to the figure title.

Second, the ministry's current methodology for collecting and reporting data on involuntary admissions was implemented in 2020/21. The ministry has informed us that the 2020/21 data is the most complete and comprehensive, but as a result of improved reporting methods, it is not directly comparable with the data previously collected, which used somewhat different criteria for identifying involuntarily admitted patients. We include the 2020/21 data in the long-term data analysis because it adds to the picture of general trends in involuntary admissions. The ministry has also indicated that since the 2020/21 involuntary admissions occurred during the beginning of the COVID-19 pandemic, this may have impacted both the type and volume of patients admitted, which adds a layer of complexity to comparing 2020/21 data and earlier data.

At present, the ministry's reporting for involuntary admissions is divided into three categories of patients: Main Diagnosis, Other Diagnosis, and Diagnosis Not under the *Mental Health Act.*[27] When comparing involuntary and voluntary patients, we only use the Main Diagnosis category data,

[25] Figures 1 and 2 in *Committed to Change*, pp. 14–15.

[26] Provided on October 12, 2021, by the Ministry of Health, Health Sector Information, Analysis and Reporting Division.

[27] Recently, the ministry has updated the names for these categories as follows: "Main Diagnosis" is now "Mental disorder treated as the main diagnosis;" "Other Diagnosis" is now "Mental disorder comorbidity with a main medical diagnosis;" and "Diagnosis Not under the *Mental Health Act*" is now "Unspecified mental disorder with or without a medical comorbidity." For clarity and readability, we use the original categories in this report. The ministry has indicated that "Main Diagnosis" means the largest proportion of a patient's treatment was for a diagnosis that fell under the *Mental Health Act*. Involuntarily and voluntarily admitted patients are easily identified within this diagnosis category. "Other Diagnosis" means the patient had a mental disorder comorbidity, which had 1) clinical significance to their case (pre-admit, admitting, proxy, service transfer, post-admit, or secondary diagnosis types) and 2) fell under the *Mental Health Act*, but the largest proportion of the patient's treatment was for a medical diagnosis. Involuntarily admitted patients are identified within this diagnosis category, but voluntary patients are not clearly identified. "Diagnosis Not under the *Mental Health Act*" means the patient had an unspecified mental disorder diagnosis reported to the Ministry; records containing codes for "self-harm"/"poisoning" and/or "other symptoms/signs involving emotional state" and any/all of Forms 4, 6, 21 were completed for the patient. Due to the unspecified mental disorder, the ministry could not provide an equivalent voluntary group for comparison, and we only have data for involuntary patients within this diagnosis category.

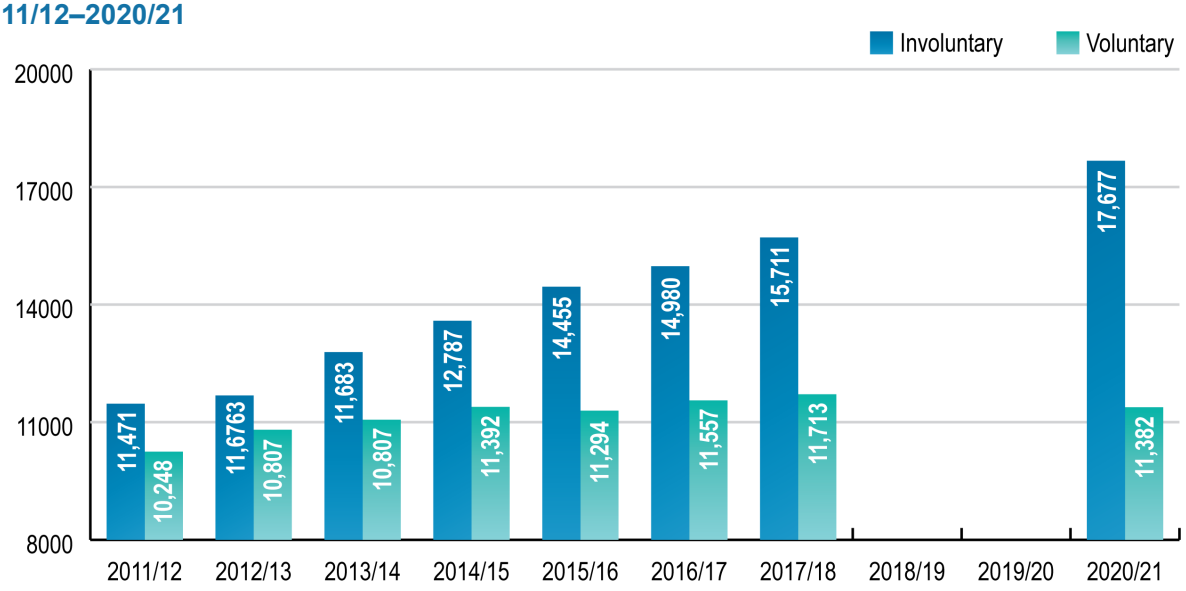
because the other two categories do not have the equivalent voluntary patient information.[28] This means some patients (involuntary and voluntary) are not included in some of the figures because the equivalent voluntary patient data is not available for the Other Diagnosis and Diagnosis Not under the *Mental Health Act* categories. Focusing on Main Diagnosis category data may exclude some involuntary patients under the other two categories, but it best answers the questions: for the patients whose main diagnosis led to them being admitted under the *Mental Health Act*, how many are voluntary, how many are involuntary and are there any changes in these numbers over time?[29] Consequently, when we compare data between voluntary and involuntary patients, using only the Main Diagnosis category, this is indicated in the figure title. When the figure only includes data for involuntary patients, we are able to include all three diagnosis categories, and this is also indicated in the figure title.

[28] The ministry has indicated that involuntarily and voluntarily hospitalized patients are identified within the 'Other Diagnosis' category. However, the broad nature of the category, which includes patients who were in hospital for treatment of other health issues not primarily mental health, results in a very high number of 'voluntary' patients (over 20,000 each year).

[29] However, we encourage the ministry to publish its full data related to voluntary and involuntary admissions under the *Mental Health Act*.

Figure 1a recreates and updates Figure 1 from the 2019 *Committed to Change* report, which compares the number of unique voluntary and involuntary patients that were discharged from Schedule B and C facilities within a fiscal year.[30] Reporting on unique patients means that even if a person was involuntarily or voluntarily admitted multiple times over a year, they are only "counted" in this figure once.[31] Although it is not possible to directly compare 2020/21 with previous years, we include this figure because, consistent with data from 2011/12 to 2017/18, it shows an increase in the volume of involuntarily admitted patients over time, while the volume of voluntary patients remains steady over the years.[32]

Figure 1a. All discharges of unique voluntary and involuntary patients from Schedule B and C facilities[33] designated under the *Mental Health Act* by fiscal year, Main Diagnosis category, 2011/12–2020/21



Note: *The total unique patient count for 2018/2019 is 27,890 (voluntary and involuntary patients combined) and for 2019/2020 is 28,799 (voluntary and involuntary patients combined) under Main Diagnosis category.*

[30] Schedule B and C facilities are public hospitals, or parts of a public hospital, that have been designated as psychiatric units (Schedule B) or observation units (Schedule C). The discharge statistics mentioned above do not include discharges of involuntary patients from mental health tertiary care (Schedule A) facilities. These facilities offer specialized psychiatric care over an extended period of time, which results in much longer average stays. Individuals may remain at these facilities for months or sometimes years. This figure differs from the original because it doesn't go back to 2005/06, it is missing data for 2018/19 and 2019/20, and it includes the most recent data we have received from the Ministry of Health for 2017/18 and 2020/21. The notes provided by the ministry state that the 2020/21 data is more accurate and therefore will have a higher number of involuntary patients than earlier years, where reporting methodologies were slightly different. Directly comparing 2020/21 to previous years is therefore not recommended.

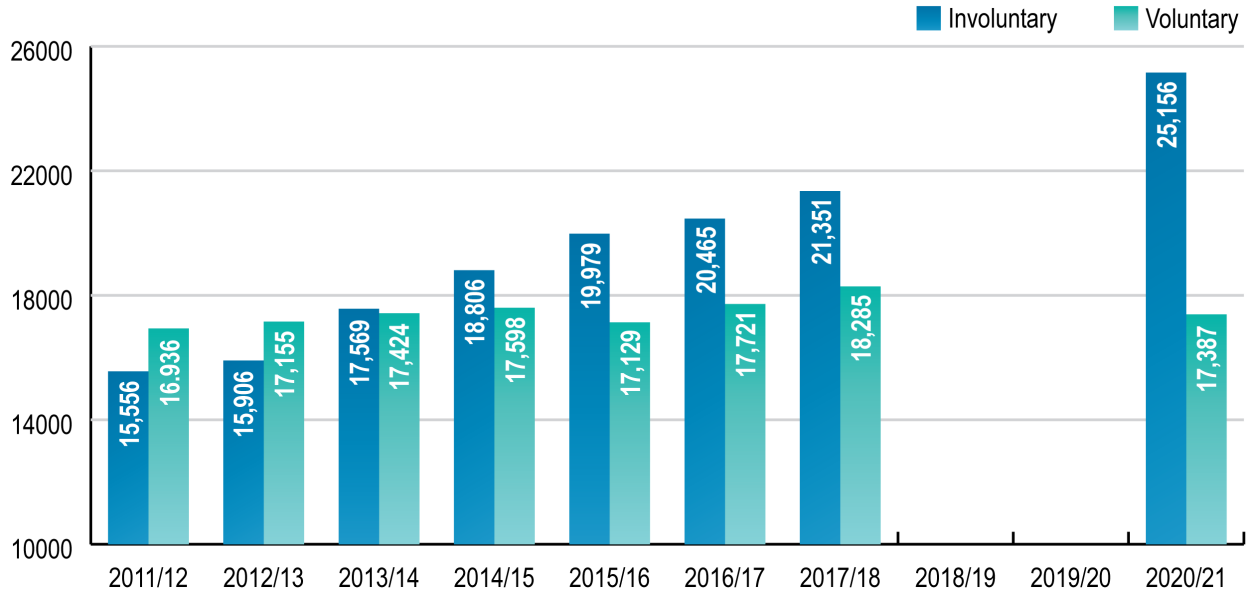
[31] In comparison, Figure 2a shows data on all discharges of voluntary and involuntary patients.

[32] Even if the higher volume of involuntary patients for 2020/21 is due to better reporting methodology, the data still indicates that the number of involuntary patients remains high and 1.5 times higher than voluntary patients. As noted earlier, the COVID-19 pandemic may have impacted the volume of patients admitted under the *Mental Health Act*, which could also account for some of the increased numbers during this year.

[33] The data provided by the ministry included some schedule A facilities (Hillside Psychiatric Centre, South Hills Tertiary Psych Rehab Centre, and Jack Ledger patients at Queen Alexandra Centre for Children's Health) that we could not remove from the data. In keeping with the original *Committed to Change* report, we also did not include Riverview Hospital data in this figure as this facility was closed in 2012.

Figure 2a is an updated recreation of Figure 2 from the 2019 *Committed to Change* report, which includes the most recent data received from the ministry.[34]

Figure 2a. All discharges of voluntary and involuntary patients from Schedule B and C facilities[35] designated under the *Mental Health Act* by fiscal year, Main Diagnosis category, 2011/12–2020/21



Note: *The total unique patient count for 2018/2019 is 39,674 (voluntary and involuntary patients combined) and for 2019/2020 is 40,782 (voluntary and involuntary patients combined) under Main Diagnosis category.*

Figure 2a shows data from the Main Diagnosis category only, and it highlights some differences between counting "unique patients" and counting patients discharged multiple times within a fiscal year.[36]

In addition to the information provided in Figures 1a and 2a, the ministry also collects some socio-demographic data on sex and age relating to involuntary and voluntary patients. This information is set out in Appendix C. As we noted in *Committed to Change*, there is very little publicly available information about involuntary admissions in British Columbia, and we encourage the ministry to make public its available data. Disaggregated socio-demographic data in particular can help reveal patterns of inequality and lead to better policy outcomes for those who

[34] This figure is also different from the original because it does not go back to 2005/06 and is missing data for 2018/19 and 2019/20.

[35] The data provided by the ministry for this figure included some schedule A facilities (Hillside Psychiatric Centre, South Hills Tertiary Psych Rehab Centre, and Jack Ledger patients at Queen Alexandra Centre for Children's Health) and Riverview Hospital data that we could not remove.

[36] Once more, 2020/2021 is not directly comparable with previous years due to more accurate reporting methods; however, the data shows that involuntary patients are 1.4 times more likely to be admitted more than once within this year than voluntary patients. While voluntary patients were more frequently admitted multiple times than involuntary patients in 2011/12 and 2012/13, over time this pattern has shifted. Involuntary patients are increasingly admitted multiple times within a year, whereas the frequency for multiple admissions per year for voluntary patients has flattened out over time.

may be disproportionately and negatively impacted.[37] By showing how sex and age intersect with involuntary or voluntary patient status, this data identifies disparities between involuntary and voluntary patients, between different age groups, and between female and male patients.[38] This information increases our understanding of who is impacted by involuntary admissions and may inform systemic changes aimed at fairer processes.

[37] Office of the Human Rights Commissioner, *Disaggregated Demographic Data Collection*, pp. 28–33.

[38] The Ministry of Health currently collects data on sex under the following three categories: female, male and other. If a person identifies as neither female or male, they are counted in the total volume of patients but there is no separate data provided for patients who do not identify as female or male. The socio-demographic data we received from the ministry indicates patients in the 16–30 and 31–45 age groups are more likely to be involuntarily admitted than all other age groups (see Figures 10a and 10c in Appendix C). Young girls (ages 0–15) are also more frequently admitted, whether voluntarily or involuntarily, than their male counterparts, but the opposite holds true for all other age categories (see Figures 11a and 11b in Appendix C).

IMPLEMENTATION WORK UNDERWAY AND IMPLEMENTED RECOMMENDATIONS FROM *COMMITTED TO CHANGE*

In the three years since *Committed to Change* was released, the provincial government has fully implemented 8 of the 24 recommendations we made. Implementation work is ongoing in a further 13 of the recommendations. The government has not yet started implementation work or has made no progress on 3 recommendations.

Regular compliance audits

Many of the recommendations in *Committed to Change* were directed at strengthening oversight of and accountability for complying with the procedural safeguards in the *Mental Health Act* by ensuring that responsible staff appropriately completed the required forms.

One area of focus was the development of audit procedures and a regular system of auditing to review compliance with the involuntary admissions form completion process, including timeliness and content of the forms **(Recommendations 16 and 17)**. This system is now largely in place across all six health authorities, with support from the Ministry of Health. The ministry included audit requirements in the provincial standards it developed (discussed further below) and supported a provincial *Mental Health Act* Forms and Audit Committee, which established standardized provincial practices and auditing procedures. Quarterly audits have been underway since July 2019, and the ministry has provided summary data from audits for 2019 and 2020.[39] All health authorities have been (and continue to be) involved in this process, and Vancouver Coastal Health has co-led this work, including the development of a community of practice that meets regularly and continues to work toward implementing the recommendations from *Committed to Change*. We were impressed with the commitment and dedication these personnel brought to the process of reviewing and improving practices under the *Mental Health Act*.

We also recommended that the health authorities conduct monthly internal audits of form completion and quality with a process for providing feedback to physicians and directors. This work is complete in some health authorities and ongoing in others, and internal auditing practices differ. We are encouraged by the collaborative approach of the health authorities and the ministry to the development and implementation of audit procedures and to continually improving form completion practices and rates. As discussed further below, the audits are working as intended in identifying gaps in practice and areas for further attention and improvement. As such, we consider **Recommendation 16** to be fully implemented. Because work remains in progress in most health authorities, we consider implementation of **Recommendation**

[39] The most recent audit data provided is for 2020, and this is reflected in the figures related to form completion and quality, in this report and Appendix B. Some health authorities have informed us that their form completion and quality rates have continued to improve since that time. They have also noted that the 2020 data reflects a time period before the release of the new *Standards for Operators and Directors of Designated Mental Health Facilities*, discussed further below.

17 to be ongoing.[40] We look forward to seeing all health authorities finalize and implement their auditing processes.

Updated guidance and standards

We made several recommendations in *Committed to Change* regarding improved practices, standards and guidance to staff, physicians and others for compliance with the *Mental Health Act.* In December 2020, the Ministry of Health published *Standards for Operators and Directors of Designated Mental Health Facilities* **(Recommendation 9)**.[41] The standards address a range of issues in response to recommendations from *Committed to Change*, including enhanced accountability, auditing and reporting, training and education, and requirements for form completion.[42] We consider **Recommendation 9** to be fully implemented. However, the government has not yet codified the standards in a regulation **(Recommendation 10)** or reviewed the effectiveness of the standards **(Recommendation 11)**, as discussed further below.

The development and implementation of the standards has been an ongoing and iterative process. As part of ongoing work, the government has committed to including the perspectives of persons with lived experience of admission under the *Mental Health Act* in consultations about further development of standards and guidance, and we strongly encourage this.[43] We have heard from some community mental health advocates who have expressed concern that the government had not engaged in extensive, meaningful consultations with persons with lived experience or with community groups and advocates regarding the standards and related work to implement the recommendations from *Committed to Change*. The government has informed us of its consultation with some groups, and we encourage the government to engage further in consultations going forward.

Committed to Change also addressed specific deficiencies in practices related to authorizing treatment and the completion of consent to treatment forms **(Recommendations 2 through 5)**. All health authorities have reported that processes are in place to ensure that directors and their delegates are not authorizing treatment in circumstances where they are also the treating physician, except in circumstances were there is no alternative **(Recommendation 2)**. This direction is also provided in the new standards (Standard One), and oversight occurs as part of regular compliance auditing.

The new standards also directly address Form 5 on consent to treatment (Standards Six and Eight). Standard Eight requires that directors ensure that persons completing Form 5 tailor the description of treatment to specify the actual particularized treatment proposed for the patient, rather than use "boilerplate" language **(Recommendation 3)**. Standard Eight also requires that directors

[40] Interior Health and Northern Health have reported to us that their implementation work on this recommendation remains in progress. In addition, as discussed further below, the audit results have indicated that substantial gaps in form completion rates and in the content and quality of forms remain.

[41] Ministry of Health, *Standards for Operators and Directors of Designated Mental Health Facilities* (December 9, 2020), https://www2.gov.bc.ca/assets/gov/health/managing-your-health/mental-health-substance-use/mental-health-standards.pdf

[42] Standard One (Enhanced Accountability), Standard Two (Auditing and Reporting), Standard Four (Training and Education), and Standard Six (Requirements for Completion of Forms). Other standards address cultural safety and humility (Three), protocols with policy agencies (Five), notification of rights (Seven), consent for treatment (Eight), nomination of near relative (Nine and Ten), accessing the Mental Health Review Board (Eleven), and disclosure of personal information to third parties (Twelve).

[43] For example, the introduction to the *Standards for Operators and Directors of Designated Mental Health Facilities* states that ongoing work on the standards "will include consultations with people with lived experience of admission under the Act" (p. 2).

ensure the completion of a new Form 5 when there is a significant change to a patient's treatment plan **(Recommendation 4)**, and it reaffirms that Form 5 may only be used to authorize psychiatric treatment, not other treatment that requires the consent of the patient **(Recommendation 5)**. Form 5 completion quality is also assessed in regular compliance auditing by the health authorities, and all health authorities have reported steps that they have taken to implement these recommendations. Although we continue to have concerns about form completion (discussed further below and in Appendix B), we consider **Recommendations 2, 3, 4 and 5** fully implemented.

Improved records management

We made two recommendations directed at improving records management of *Mental Health Act* forms by the health authorities. The health authorities (with the exception of Fraser Health) have established working groups to address issues in relation to the storage, maintenance and tracking of forms, but they are still in the process of identifying and establishing province-wide best practices for records management for involuntarily admitted patients **(Recommendation 14)**.

We also recommended that health authorities require designated facilities to store and maintain *Mental Health Act* forms in a manner that is readily accessible to staff, physicians and patients **(Recommendation 15)**. The health authorities have implemented this recommendation in different ways through electronic records systems, physical forms and various organizational strategies. The Ministry of Health continues to support the health authorities in developing and improving their record management strategies. We appreciate that this will be an ongoing process, particularly as technological capacities and resources improve. We consider **Recommendation 14** to be ongoing and **Recommendation 15** to be fully implemented.

Northern Health review

Due to a finding that the University Hospital of Northern British Columbia (UHNBC) failed to ensure that consent for treatment forms (Form 5) were completed for involuntary patients who were admitted under the *Mental Health Act*, we recommended an independent review and the development and implementation of a strategy to address the issues identified **(Recommendation 1).** The Northern Health review was completed by an internal audit team, which made recommendations in a final report in September 2019. Northern Health reports that the recommendations from the review were addressed by UHNBC management, and there have been four follow-up audits to monitor compliance. Although the quarterly compliance audit process results identify continuing challenges with Form 5 in Northern Health, as discussed further below and in Appendix B, we consider **Recommendation 1** to be fully implemented.

REMAINING IMPLEMENTATION WORK

The majority of recommendations from our 2019 report have not yet been fully implemented, although some work has been done on most of them. Several of these recommendations, like those discussed above, relate to key areas of oversight and accountability **(Recommendations 6, 7, 8, 11, 14, 18, 19)** and training and guidance for staff and physicians **(Recommendations 10, 12, 13, 20)**. The previous section identified progress in implementation in these areas, and this section identifies recommendations where substantial work remains to be done. In the third key area of recommendations from *Committed to Change*, developing an independent rights advisor service **(Recommendations 21, 22, 23, 24)**, after limited progress over the past three years, recent developments have advanced implementation of these recommendations. In addition, on two recommendations, the government has indicated that legislative change to implement the recommendation is neither supported nor a priority **(Recommendations 7 and 8)**.[44]

We are concerned about this step back from commitments made in response to the original report,[45] and we expect that the government will commit sufficient resources and attention to move forward with fully implementing all outstanding recommendations.

Form completion rates

The completion rate and adequacy of required forms under the *Mental Health Act* were a primary focus of *Committed to Change*, and numerous recommendations addressed these important issues. The health authorities and the Ministry of Health have worked to develop, standardize and implement regular compliance auditing procedures and practices, as discussed above. With these processes now in place, the audits have identified ongoing inadequacies in form completion and quality. The Ministry of Health and the health authorities have provided data on form completion and quality from the most recent quarterly audit results available.[46] The audit data reveals some improvements

[44] On November 30, 2021, the government provided us with its updated status dashboard on implementation, which included reports from all health authorities and the Ministry of Health, Ministry of Attorney General and Ministry of Mental Health and Addictions. In that update, the Ministry of Health reported to us on Recommendation 7: "There is a legal requirement consistent with the *Mental Health Act* for Health Authorities/Provincial Health Services Authority-CWBC to notify the Public Guardian and Trustee when a patient does not have a near relative. The Public Guardian and Trustee have informed Ministry of Health that they don't have the resources or capacity to implement a process or develop an electronic data base that would allow the exchange of information between Health Authorities and Public Guardian and Trustee to identify those involuntary patients who are clients of the Public Guardian and Trustee or clients who have private committees. In order to implement this recommendation it will require a legislative change of the *Mental Health Act* and additional Freedom of Information requirements which is not a priority of the current government."

On Recommendation 8, the Ministry of Attorney General reported to us that implementing this recommendation "will require a legislative change of the *Mental Health Act* and the Freedom of Information requirements which is not supported by the current government." Similarly, the ministries of Health and Mental Health and Addictions reported that implementing this recommendation "will require a legislative change of the *Mental Health Act* and the Freedom of Information requirements which is not a priority by the current government."

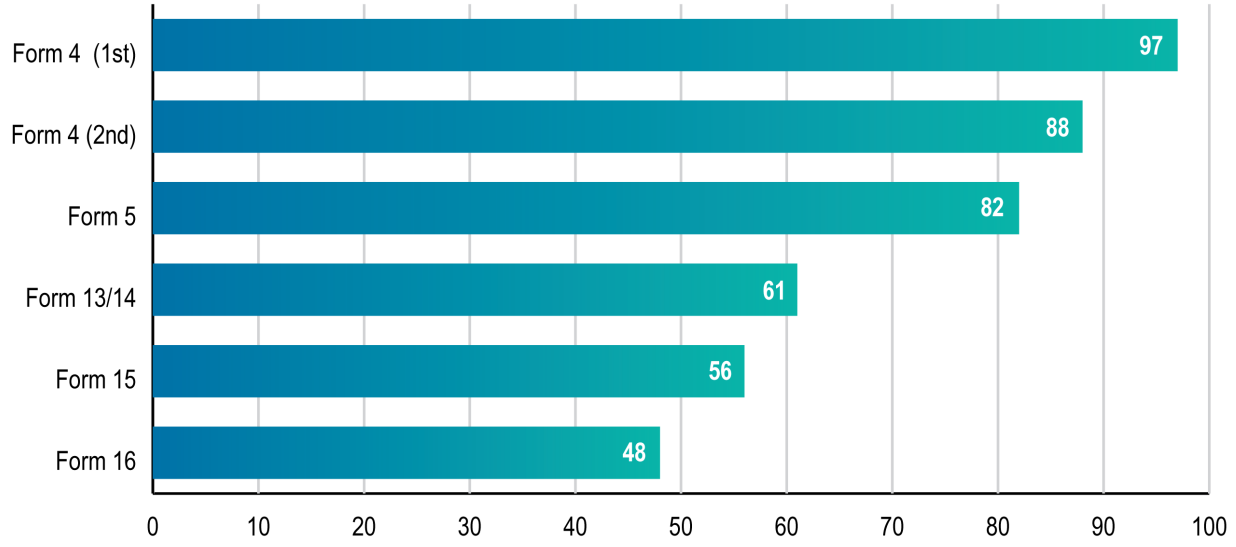
[45] Authority responses to the findings and recommendations in *Committed to Change* are included in Appendix B to that report.

[46] The information provided by the Ministry of Health is for Q4 (Oct–Dec) 2020 audit data. Health authorities have informed us that their form completion and quality rates have continued to improve since that time. They have also noted that rates may have been impacted by the release of the new *Standards for Operators and Directors of Designated Mental Health Facilities* and ongoing efforts to improve form layout.

regarding presence of forms on patient files but continued gaps in the full completion and quality of those forms.[47] This is further confirmed by complaints that our office continues to receive from individuals who have been involuntarily admitted and that raise concerns related to timely and adequate form completion.[48]

Figure 3 shows the percentage of patient files that contained each required form for involuntary admission under the *Mental Health Act* for the most recent audit period available, combining data from all health authorities (Fraser Health, Vancouver Coastal Health, Interior Health, Island Health, Northern Health and the Provincial Health Services Authority). The number of charts audited for each health authority varies, based on a formula set out in the audit instructions.[49] The audit results indicate that gaps persist in form completion across the health authorities, particularly for Forms 13/14,[50] Form 15 and Form 16.

Figure 3. Percentage of patient files containing required forms, by form, all health authorities, Oct–Dec 2020



[47] The Provincial Health Services Authority data is the only exception, but the sample size is small and some data appears to have been accidentally excluded from the calculations (as discussed further below). Northern Health in particular (and to a lesser extent Fraser Health) is underperforming when it comes to form presence, completion and quality.

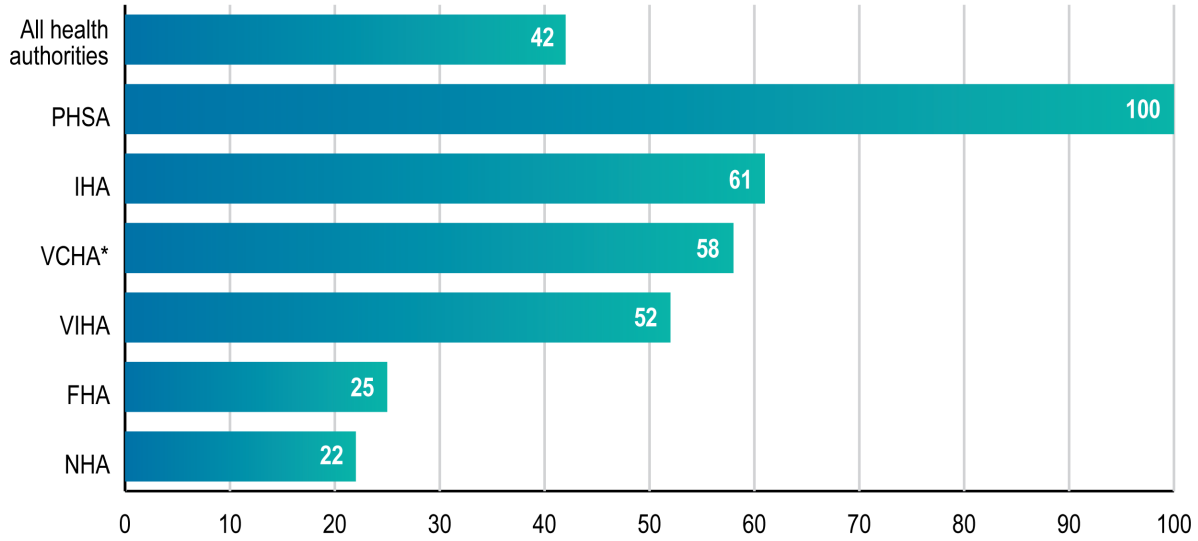
[48] For instance, involuntary patients continued to raise issues around lack of information about their rights and the process of involuntary admission, as well as timely form completion and adequacy of form completion. Among the complaints that our office has received and investigated since *Committed to Change* was published in 2019, we have observed that one or more forms were not completed correctly 44 per cent of the time.

[49] The number of charts audited for each health authority is determined by the following "formula" in the audit instructions: "Facilities with fewer than 10 eligible patients will audit all charts. Facilities with fewer than 100 eligible patients will audit 20% of all charts. Facilities with more than 100 eligible patients will audit 10% of all charts to a minimum of 20 charts and a maximum of 40 charts (or more if deemed necessary by the Mental Health Act Director of the designated facility)." The total number of charts audited for each health authority was over 100, except for the Provincial Health Services Authority, where 30 charts were audited.

[50] Form 13 (Notification to Involuntary Patient of Rights under the *Mental Health Act*) and Form 14 (Notification of Patient under 16, Admitted by a Parent or Guardian, of Rights under the *Mental Health Act*) both address the provision of rights information. Our investigation in *Committed to Change* focused on involuntary admissions and did not include Form 14, which is used in voluntary admissions of persons under 16 years of age. However, because the health authorities have included Form 14 in their audits, and the Ministry of Health provided that information, we have included it here.

Figure 4 shows the percentage of audited patient files that contained all required forms (Forms 4, 5, 13/14, 15 and 16) for involuntary admission by health authority for the same audit period, and highlights significant variation in how health authorities are meeting this standard.[51] The figure indicates that the forms were present in a patient's chart, but it does not indicate to what extent they were fully completed or the quality of that completion. See Appendix B for figures comparing the percentage of patient files that contained all of the required forms (Forms 4, 5, 13/14, 15 and 16) with the percentage of these forms that were assessed as fully completed (completion rates), as well as the quality of form completion for required forms under the *Mental Health Act* by form. The figures in Appendix B reveal further gaps between form presence and form completion and quality.[52]

Figure 4. Percentage of patient files containing all required forms (Form 4 (1st and 2nd), Form 5, Form 13/14, Form 15 and Form 16), by health authority, Oct–Dec 2020[53]



[51] Over 100 charts were audited for each health authority other than the Provincial Health Services Authority (PHSA), which had a significantly smaller sample size of 30 charts. Of these 30 charts, 30 Form 5s, 13s, 15s, and 16s were present, although only 15 of the Form 4s (1st and 2nd) were counted. It is possible that 15 of the Form 4s were completed at another facility, and in this case the *Mental Health Act* Audit Instructions state that "Mental Health Act Directors are responsible only for forms required, attempted or completed in the facility for which they provide oversight." Therefore, if the PHSA has 30 Form 4s but some of them were completed at another facility, it would still count the 30 for presence on the chart, but would only examine the quality of the Form 4s that were completed by PHSA staff. This issue also arises with Island Health.

[52] Appendix B includes figures regarding form completion and quality for Forms 4 (1st), 5, 13/14, 15 and 16, based on information provided by the ministry from health authority audits for the period October–December 2020.

[53] The asterisk (*) for VCHA indicates that this data includes patients admitted to St. Paul's Hospital, operated by Providence Health Care in partnership with Vancouver Coastal Health. This data was based on the audit information shared to us by the health authorities, and calculated based on the number of the "Total # Charts Audited with All Required Forms" divided by the"Total # Charts Audited" for each health authority. The ministry has informed us that the percentages are different but it has not provided more information or explanation. As such, we have kept the figure based on the data we received, and we encourage the ministry and the health authorities to make public other data they have available.

When we met with members of the health authorities' community of practice on implementation, they acknowledged the ongoing challenges in attaining 100 per cent compliance and indicated their continuing focus on improving quality as well as form completion. We underscore the importance of these forms, which provide the legal authority for an involuntary admission and detention under the *Mental Health Act*, and we strongly encourage further work by health authority staff, with support from the Ministry of Health and the Ministry of Mental Health and Addictions, to ensure timely and appropriate completion of all required forms.

Notification of Near Relative, Public Guardian and Trustee, or Representative (Form 16)

Form 16 is intended to fulfill the critical function of advising someone who can provide support that a patient has been involuntarily admitted and detained. Our original investigation identified concerns about Form 16 completion practices, procedures for notifying the Public Guardian and Trustee of British Columbia (PGT), and the lack of notification of other third parties with the ability to assist a patient who does not have a near relative and is not a PGT client. **Recommendations 6, 7 and 8** in *Committed to Change* are directed at addressing these concerns.

Form 16 completion is included in regular compliance auditing, and practices for notifying near relatives, including confirmation of receipt, are addressed in Standard Ten of the new *Standards for Operators and Directors of Designated Mental Health Facilities*. Work is underway, but not yet complete, in all health authorities to develop a process to confirm receipt of each Form 16 by its addressee or, if needed, to issue a further Form 16 **(Recommendation 6)**.

Unfortunately, there has not been comparable progress on related recommendations to:

- develop and implement, in consultation with the PGT and the Office of the Information and Privacy Commissioner, an appropriate method for identifying in a timely way those involuntary patients who are clients of the PGT or who have private committees **(Recommendation 7)**
- introduce legislative amendments to the *Mental Health Act* to improve notification to the PGT and expand notification to others such as a patient's representative or attorney, or an independent rights advice body **(Recommendation 8)**

In its most recent update to our office, the government indicated that legislative changes to implement these recommendations are not a priority or are not supported by the current government.[54] The Ministry of Health and the Ministry of Mental Health and Addictions have subsequently reiterated that they had only accepted these recommendations "in principle."[55] For its part, the PGT has now told us that they do not support the implementation of a process to identify involuntary patients who are clients of the PGT or who have private committees. While we are concerned about the stated lack of intention to proceed with implementation of **Recommendations 7 and 8** as written, we believe they can be implemented by ensuring that the rights advisor is notified of all involuntary admissions (as provided in **Recommendation 21**) and then provided the authority to make inquiries of the PGT or other bodies as needed to determine whether the patient is a client of the PGT and/or has a private committee, a

[54] This was stated in the November 30, 2021, updated status dashboard on implementation, which is quoted in footnote 44.

[55] Letter from the Ministry of Mental Health and Addictions and the Ministry of Health, dated June 20, 2022. The ministries also indicated that these determinations regarding legislative change are the result of extensive review, analysis, and consultation.

known representative under a Representation Agreement or an attorney under an Enduring Power of Attorney. Until these steps are taken, however, we consider that there has been no progress on implementing **Recommendations 7 and 8**. If the Ministry of Health and the Ministry of Mental Health and Addictions are of the view that implementation of these recommendations as originally written is not feasible, then we would encourage them to take other steps that would address the concerns that led us to make these recommendations, including by ensuring the rights advisors are able to contact the PGT as needed to determine whether a patient is a PGT client. We are encouraged that the Ministry of Attorney General has indicated its readiness to collaborate with the Ministry of Health on additional policy work that may be needed.

Updated regulation and guide

The ministry has published *Standards for Operators and Directors of Designated Mental Health Facilities* **(Recommendation 9)**[56] but has not yet taken related steps recommended to strengthen oversight and accountability, and to provide guidance for staff, physicians and others. These are:

- codifying the standards in a regulation **(Recommendation 10)**
- reviewing the effectiveness of the standards and publicly reporting the results, including compliance rates for each health authority **(Recommendation 11)**
- updating and reissuing the *Guide to the Mental Health Act* **(Recommendation 20)**

The government has informed us that it is currently undertaking a review and update of all *Mental Health Act* forms and, following this, it will update the standards and the guide. The government informed us that it expected the update of the guide to be completed by May 2022 and the review of the standards to be completed in 2023. We expect that these processes will include meaningful consultations with persons with lived experience and with community groups and mental health advocates. The government has also indicated that work is underway to publicly report the 2020 audit results. We encourage the government to continue implementing these outstanding recommendations that advance accountability and transparency.

Mandatory training

Training for staff and physicians regarding the necessity of form completion was a key area for recommendations in *Committed to Change*. We recommended that the Ministry of Health, together with health authorities, conduct a review of training offered to directors, physicians and staff exercising authority under the involuntary admissions provisions of the *Mental Health Act*, and revise all training materials, policies and procedures to address the deficiencies identified in our report **(Recommendation 12)**. We also recommended that the Ministry of Health and the health authorities develop and implement a mandatory training plan; ensure completion of the training by existing directors, physicians and staff; and ensure that new staff complete the training within one month of hiring **(Recommendation 13)**. We expected implementation of this recommendation by September 30, 2019.

The Ministry of Health completed its review in 2019 and shared with us all of the educational tools developed by the health authorities. The new *Standards for Operators and Directors of Designated Mental Health Facilities* require directors, physicians and staff of designated mental health facilities to complete provincially approved educational modules (Standard Four). Some summary data on training completion rates is provided by the health authorities in the quarterly audit process. The

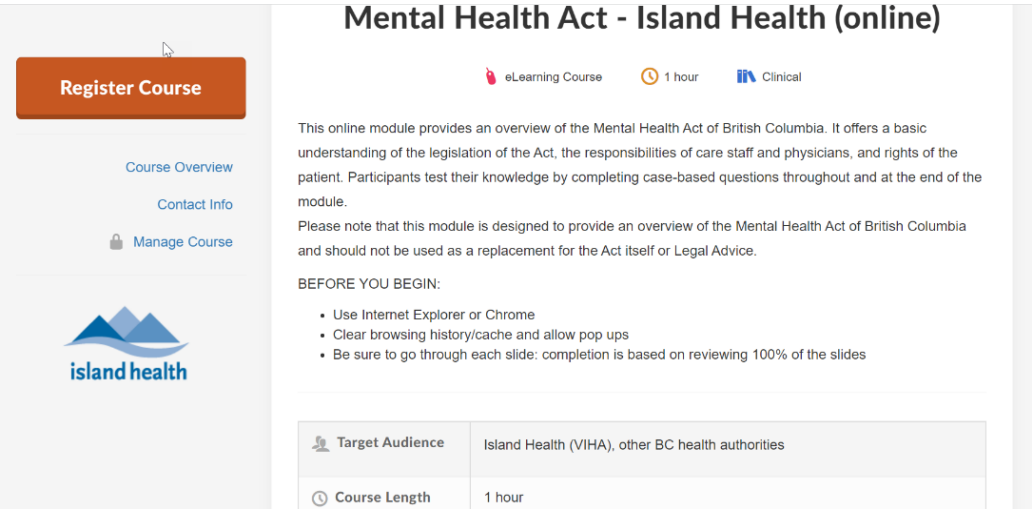
[56] *Standards for Operators and Directors of Designated Mental Health Facilities*.

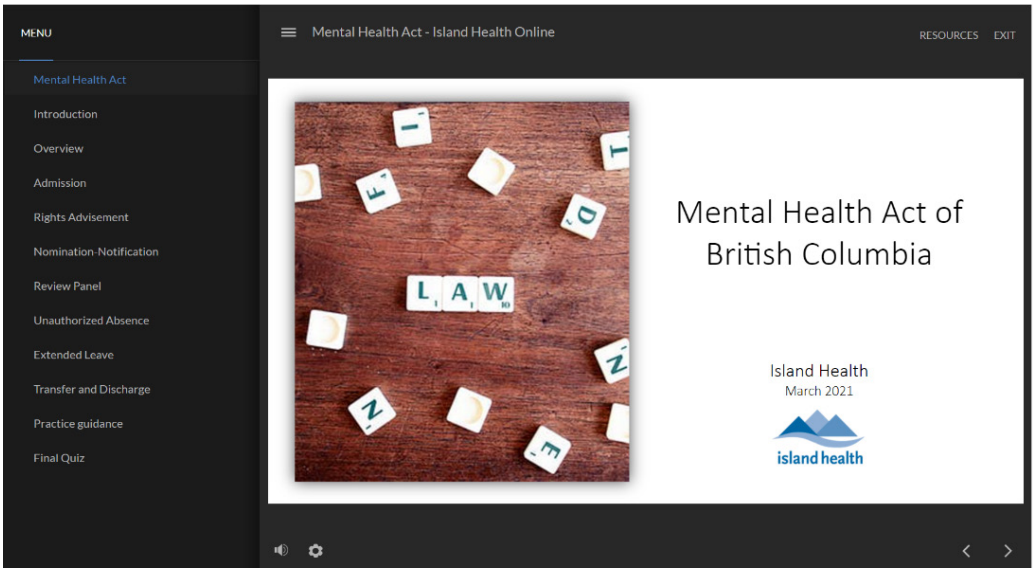
ministry has also established an advisory committee to develop provincial standards for *Mental Health Act* educational and training materials.

Other work on these recommendations remains ongoing. All of the health authorities have provided current information on their progress in revising training materials, policies and procedures; developing and implementing mandatory training plans; and achieving completion of the training by directors, physicians and staff.

For example, Island Health provided an overview and materials from its current online course on the *Mental Health Act*.[57] The course is open to employees and physicians in Island Health and other health authorities, and to the public. It was most recently updated in March 2021 to reflect the new standards. Vancouver Coastal Health also has an online course that is available to the public as well as employees and physicians. Screenshots from the Island Health course are included below.

Course overview and menu – Online





[57] Island Health summary of *Mental Health Act* education plans, education and practice support tools (October 2021), provided to us in November 2021. Vancouver Coastal Health provided similar materials and access to its online course.

Some health authorities are further along in implementation, and others are earlier in the process of developing and implementing training plans. Fraser Health noted that its work on extending the training requirement and developing tracking methods had been delayed by its COVID-19 responses. Although the health authorities have not yet fully implemented **Recommendations 12 and 13**, we are pleased with the scope of work underway toward implementation.

Performance measures

To further support oversight and accountability, we recommended that 100 per cent compliance with form completion be established as a yearly performance measure for each designated facility **(Recommendation 18)** and for the chief executive officer of each health authority **(Recommendation 19)**. All of the health authorities have adopted some method for regularly sharing audit results and other quality improvement data with senior management. Some health authorities have expressed concern about the implications of this recommendation (Vancouver Coastal Health, Island Health). We commend these ongoing efforts to share audit results and improve form completion and quality. However, we are not satisfied with the level of implementation work to date. These practices do not implement our recommendations, as they do not establish senior management accountability for compliance with key provisions of the *Mental Health Act*. We strongly encourage continued work to develop the performance measures and to implement **Recommendations 18 and 19**.

Independent rights advisory service

The third key area of recommendations from *Committed to Change* related to the development of an independent rights advisor service that would work in designated facilities in the province and provide advice to patients about the circumstances of their detention and their options if they disagree with a detention or a related decision **(Recommendations 21, 22, 23, 24)**. The existing requirement under the *Mental Health Act* for the director to provide rights information to patients remains essential for compliance with section 10 of the *Canadian Charter of Rights and Freedoms*. However, for the reasons detailed in *Committed to Change*, providing rights information through Form 13/14 is not sufficient to adequately protect the rights of individuals who are involuntarily admitted.[58]

Recommendation 21 suggested a specific approach to the development of the independent rights advisory service:

> *By November 1, 2019, government mandate the Legal Services Society to deliver directly or through another body independent rights advice and advocacy to involuntarily admitted patients in all designated facilities, including introducing, for consideration by the legislative assembly, legislative changes to:*
>
> *a. require directors of designated facilities to notify the independent rights advice body of every involuntary admission, transfer or renewal of detention in the province within 24 hours*

[58] We note that community advocates also continue to call for independent legal advice services for people detained under the *Mental Health Act*. For example, a recent post by the British Columbia Law Institute addressed this in the context of access to justice (L. Johnston, "Why Independent Legal Advice Services Matter for People Detained under the *Mental Health Act*," February 16, 2022, https://www.bcli.org/why-independent-legal-advice-services-matter-for-people-detained-under-the-mental-health-act/) and community organizations have developed "A Community Vision for Independent Legal Advice Services" (https://www.healthjustice.ca/access-to-justice).

b. *provide the independent rights advice body with the power to obtain any patient records relating to the involuntary admissions procedure that may be prescribed under the Mental Health Regulation; and*

c. *require directors of designated facilities to ensure that each facility provides a method for facilitating private communication between involuntary patients and the rights advice body.*

The remaining recommendations were that the enabling legislation be brought into force by April 2020 **(Recommendation 22)**, that the independent rights advice body be provided with funding **(Recommendation 23)**, and that implementation and funding be reviewed within one year **(Recommendation 24)**.

Implementation of this set of recommendations has not proceeded on the time frame contemplated in *Committed to Change*. However, on April 28, 2022 the Attorney General introduced Bill 23 to amend the *Mental Health Act* to enable the development of a rights advice service. The legislation received royal assent on June 2, 2022, and the Ministry of Attorney General has informed us that the legislation will come into force through regulation when the rights advice service is ready to be launched province wide.[59] This would be an important step in the development of an independent rights advice service for involuntarily admitted patients.

Over the past three years, the Ministry of Attorney General, working with the Ministry of Health and the Ministry of Mental Health and Addictions, has convened a working group and steering committee to explore potential models for the provision of independent rights advice to patients admitted under the *Mental Health Act* **(Recommendation 21)**. They have conducted consultations with health authorities, designated facility operators, mental health and legal advocacy organizations, professional associations, the Mental Health Review Board, and individuals and families with lived experience of the involuntary mental health system. They have also connected with other Canadian provinces that have established similar rights advice services.[60] The new legislation lays the foundation for an independent rights advice service by authorizing the Attorney General to contract with other parties for the provision of rights advice services. The new legislation appears to contemplate the rights advice service initially as an information and referral service, provided primarily virtually and based upon patient request.[61] It also includes broad regulation-making powers that would enable further development of the rights advice service.

While the new legislation is an encouraging step, it leaves substantial issues remaining for government to address as the independent rights advice service is developed.

A key component of **Recommendation 21** was that the Legal Services Society be mandated to deliver the rights advice service, either directly or through another body. This is because public accountability – including through complaints to our office – is essential to the service. The legislation introduced would permit non-publicly accountable entities to be carrying out a service mandated in statute. This a departure from the oversight

[59] Letter from the Ministry of Attorney General, dated June 7, 2022.

[60] Hon. David Eby (April 28, 2022), https://www.leg.bc.ca/documents-data/debate-transcripts/42nd-parliament/3rd-session/20220428am-House-Blues; Bill 23-2022, https://www.leg.bc.ca/parliamentary-business/legislation-debates-proceedings/42nd-parliament/3rd-session/bills/first-reading/gov23-1

[61] Ministry of Attorney General, "New service helps clarify rights under Mental Health Act" (news release, April 28, 2021), https://news.gov.bc.ca/releases/2022AG0026-000657

structure that exists in most other provinces that have a rights advisor or similar role. In those provinces, the Ombudsperson has jurisdiction to investigate complaints about the rights advisor service directly. The public accountability and oversight that an Ombudsperson provides should be included as part of the development of this service, particularly given that the rights advisors will be carrying out a statutory function. The ministry has informed us that work on accountability mechanisms is still ongoing.

In addition, we would expect that the ongoing work to develop the rights advice service would be done with reference to our recommendations that the rights advisor be automatically notified of every involuntary admission, transfer or renewal within a defined period, and that the rights advisor provide "independent rights advice and advocacy," which would include – at a minimum – taking steps at the request of the patient to contact people who can protect the patients' rights. This may include, but would not necessarily be limited to, communicating with a facility about the patient's concerns; facilitating an application for legal aid or to the review board; contacting the person's committee, representative, or attorney (as applicable); contacting an advocate or family member; and contacting the Mental Health Law Program at CLAS, a First Nations Justice Centre, Access Pro Bono or a private practice lawyer. These are also essential components of a robust and effective rights advice system.

As the audit process and quality improvement efforts have illustrated, there remain ongoing challenges in form completion and quality across the health authorities, including the provision of rights information through Form 13/14.[62] Our office also continues to receive complaints that raise concerns about the lack of information on rights for individuals who have been involuntarily admitted. It is evident that more substantial tools are needed to protect the rights of involuntarily admitted persons.

We welcome the new legislation to enable the development of a rights advice service as an important step toward implementing **Recommendation 21**. In reporting on implementation, the Ministry of Attorney General has indicated that work on **Recommendations 22, 23, and 24** will follow work on **Recommendation 21**. We assess the implementation work as ongoing for **Recommendations 21, 22 and 23**. As that work moves forward, we expect the government to shift focus to how involuntarily admitted patients are supported financially in accessing legal aid to exercise their legal rights. The Ministry of Attorney General has committed to working closely with the Legal Aid BC, the Community Legal Assistance Society, and the Mental Health Review Board, once the rights advice service is implemented, to monitor and respond to any increase in requests for representation. In the meantime, we assess that there has been no progress on implementing **Recommendation 24**. We will continue to remain engaged in oversight as the process of developing the rights advice service moves forward, and we look forward to seeing how the rights advice service works in practice. We urge the government to continue to work expeditiously toward the implementation of an independent rights advisory service to inform patients of their legal rights, to provide advice and advocacy, and to help ensure that involuntary detentions are lawful and that procedural safeguards are followed for all patients.

[62] The most recent audit data regarding Form 13 (Notification of Rights) completion rates and quality is provided in Figures 7a and 7b in Appendix B.

Conclusion

This monitoring report is being released three years after the original *Committed to Change* report, and two years after the start of the COVID-19 pandemic in British Columbia. Our assessment recognizes this larger context and the provincial government's efforts to prioritize and address a number of ongoing challenges related to mental health, substance use, reconciliation, anti-racism and equity. In this context, the issues raised in *Committed to Change* will continue to be relevant. We are encouraged by some of the work to advance systems of oversight and accountability, including improved compliance auditing, but are concerned about the limited progress on many other recommendations. In the critically important development of an independent rights advisory service, we will be paying close attention to implementation.

We wish to acknowledge the ongoing work by public servants in the ministries and health authorities who, over the period of monitoring by our office, have provided information and engaged in discussions with our office about implementation. The current requirements of the *Mental Health Act* and the complexities of mental health treatment make it challenging to bring about systemic change, but such change cannot occur without the efforts of dedicated public servants.

We look forward to seeing the ongoing work of the ministries, health authorities, working groups and communities of practice, and others who have taken on many of the issues highlighted in this report and who will continue to push them forward. We will continue to monitor and report publicly on the implementation of the remaining recommendations from *Committed to Change.*

RECOMMENDATIONS SUMMARY

R1	By September 30, 2019, the board of directors of Northern Health Authority: a. appoint an independent reviewer to produce a written report outlining the reasons for low Consent for Treatment (Form 5) compliance rates at the University Hospital of Northern British Columbia, and require the reviewer to provide the completed report to the board of directors, chief executive officer and the Ministry of Health b. in consultation with internal stakeholders and the Ministry of Health, approve a strategy to address the issues identified in the report c. work with internal stakeholders and the Ministry of Health to implement the resulting strategy, and d. ensure that the results of the monthly audits conducted in accordance with Recommendation 17 examine the effectiveness of the strategy in improving Compliance.	**Fully implemented**
R2	Beginning immediately, the health authorities require directors of designated facilities, and their delegates, to cease the practice of authorizing treatment in circumstances where they are also the treating physician, except in circumstances where there is no alternative.	**Fully implemented**
R3	Beginning immediately, the health authorities require all persons responsible for completing consent for treatment forms (Form 5) in the designated facilities to cease using boilerplate language to describe a proposed course of treatment in Form 5s and to tailor the description of treatment to specify the actual particularized treatment proposed for the individual patient.	**Fully implemented**
R4	Beginning immediately, the health authorities require the designated facilities to apply the policy guidance set out in the Guide to the *Mental Health Act* and require all persons responsible for completing consent for treatment forms (Form 5) to complete a new Form 5 when there is a significant change to a patient's treatment plan.	**Fully implemented**
R5	Beginning immediately, the health authorities: a. instruct the directors of designated facilities to cease purporting to authorize non-psychiatric treatment of involuntary patients by way of consent for treatment forms (Form 5), and b. instruct all staff that non-psychiatric treatment of involuntary patients can only be administered in accordance with Part 2 of the Health Care (Consent) and Care Facility (Admission) Act or the Infants Act.	**Fully implemented**

R6	By January 1, 2020, the health authorities develop a process for implementation by the directors of designated facilities by February 1, 2020, to confirm receipt of each Notification to Near Relative (Form 16) by its addressee, and, if the form was not received, to issue a further Form 16 to another near relative of the patient.	**Ongoing**
R7	By January 1, 2020, the Ministry of Health and the health authorities develop and implement, in consultation with the Office of the Information and Privacy Commissioner and the Public Guardian and Trustee of British Columbia, an appropriate method for identifying, in a timely way, those involuntary patients who are clients of the Public Guardian and Trustee of British Columbia or who have private committees.	**No progress**
R8	By November 1, 2019, government introduce legislation for consideration by the legislative assembly to amend the *Mental Health Act* to: a. repeal section 34.2(4), which provides that a director's duty to notify a patient's near relative is discharged if a notice is sent to the Public Guardian and Trustee of British Columbia (PGT) b. require the directors of designated facilities to identify patients who are clients of the PGT or who have a private committee and notify the PGT upon those patients' admission, transfer or renewal of detention c. require the directors of designated facilities to notify any known representative under a Representation Agreement or attorney under an Enduring Power of Attorney upon those patients' admission, transfer or renewal of detention, and d. provide that where there is no known near relative, representative, attorney or committee, and the patient is not a client of the PGT, the notice be provided to the independent rights advice body in accordance with the process described under Recommendation 21.	**No progress**
R9	By June 30, 2019, the Ministry of Health and the Ministry of Mental Health and Addictions work together with the health authorities to establish clear and consistent provincial standards aimed at achieving 100 per cent compliance with the involuntary admissions procedures under the *Mental Health Act* through the timely and appropriate completion of all required forms	**Fully implemented**
R10	By June 30, 2019, the Ministry of Mental Health and Addictions establish a regulation under section 3(1) of the Health Authorities Act to codify the standards developed in accordance with Recommendation 9.	**Ongoing**

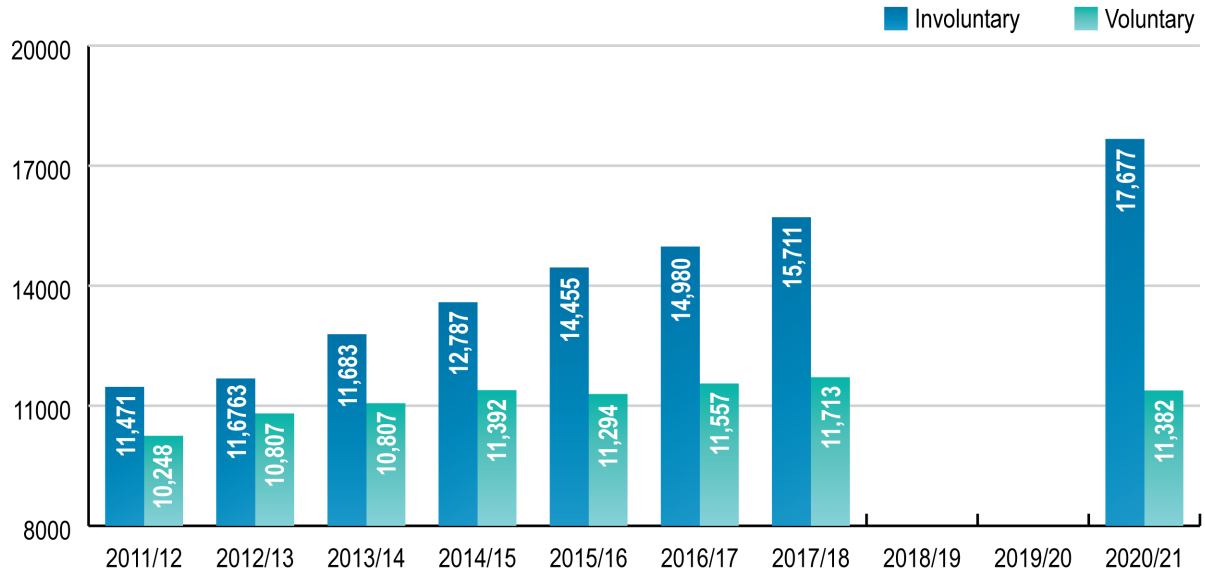
R11	By June 30, 2020, June 30, 2021, and June 30, 2022, the Ministry of Mental Health and Addictions and the Ministry of Health review the effectiveness of the provincial standards developed in accordance with Recommendation 9 to achieve compliance with the involuntary admissions process under the *Mental Health Act*, and publicly report the results of each of their reviews, including the compliance rates for each health authority for the previous fiscal year.	**Ongoing**
R12	By September 30, 2019, the Ministry of Health, together with the health authorities, conduct a review of the training that is offered to directors, physicians and staff exercising authority under the involuntary admissions provisions of the *Mental Health Act,* and revise all training materials and policies and procedures to address the deficiencies identified in this report, including a focus on the substantive completion of medical certificates and consent for treatment forms	**Ongoing**
R13	By September 30, 2019, the Ministry of Health, together with the health authorities, develop and implement a mandatory training plan for all directors, physicians and other staff exercising authority under the involuntary admissions provisions of the *Mental Health Act*, and ensure that those individuals complete the revised training by March 31, 2020, and all new staff complete the training within one month of hire.	**Ongoing**
R14	The health authorities establish a working group to address issues in relation to the storage, maintenance and tracking of *Mental Health Act* forms and, by January 1, 2020, identify and establish province-wide best practices for records management for involuntarily admitted patients.	**Ongoing**
R15	Beginning immediately, the health authorities require the designated facilities to store and maintain *Mental Health Act* forms in a manner that makes them readily accessible to staff, physicians and patients.	**Fully implemented**
R16	By June 30, 2019, the health authorities establish audit procedures and begin auditing, on a quarterly basis, the designated facilities' compliance with the involuntary admissions form completion process and report the results of the audit to the Ministry of Health and the Ministry of Mental Health and Addictions.	**Fully implemented**
R17	By June 30, 2019, the health authorities establish procedures respecting monthly internal audits of the involuntary admissions form completion process, including in relation to timeliness and the content of the forms, for the designated facilities to implement by September 30, 2019. The audit process should be carried out by someone sufficiently senior to provide feedback to physicians and directors regarding compliance with the involuntary admissions process, including the adequacy of reasons on medical certificates and the adequacy of treatment descriptions on consent for treatment forms.	**Ongoing**

R18	By March 31, 2020, the health authorities establish 100 per cent compliance in form completion for the involuntary admissions process under the *Mental Health Act* as a yearly performance measure for each designated facility.	**Ongoing**
R19	By March 31, 2021, the board of directors for each health authority establish a 100 per cent rate of compliance in form completion for the involuntary admissions process under the *Mental Health Act* as a yearly performance measure for the chief executive officer of each health authority.	**Ongoing**
R20	By March 31, 2020, the Ministry of Health update and reissue the *Guide to the Mental Health Act* to incorporate the changes made arising from this report and other changes.	**Ongoing**
R21	By November 1, 2019, government mandate the Legal Services Society to deliver directly or through another body independent rights advice and advocacy to involuntarily admitted patients in all designated facilities, including introducing, for consideration by the legislative assembly, legislative changes to: a. require directors of designated facilities to notify the independent rights advice body of every involuntary admission, transfer or renewal of detention in the province within 24 hours b. provide the independent rights advice body with the power to obtain any patient records relating to the involuntary admissions procedure that may be prescribed under the Mental Health Regulation; and c. require directors of designated facilities to ensure that each facility provides a method for facilitating private communication between involuntary patients and the rights advice body.	**Ongoing**
R22	By April 1, 2020, if passed by the legislative assembly, the legislation referred to in Recommendation 21 be brought into force.	**Ongoing**
R23	By April 1, 2020, the Ministry of Attorney General provide funding to the Legal Services Society sufficient to allow the independent rights advice body to provide advice and advocacy services to involuntarily admitted patients in all designated facilities.	**Ongoing**
R24	Within one year of the implementation of the rights advice service referred to in Recommendation 21, the Ministry of Attorney General review the amount of legal aid funding available for patients who wish to apply to the court to exercise legal rights arising from their involuntary admissions and detentions, and ensure that sufficient legal aid funding is provided on an ongoing basis for all patients who wish to make such applications and meet the usual financial eligibility criteria and assessment of prospects for success of the legal proceeding.	**No progress**

APPENDIX A: INVOLUNTARY ADMISSIONS DATA

Figure 1a recreates and updates Figure 1 from the 2019 *Committed to Change* report, which compares the number of unique voluntary and involuntary patients that were discharged from Schedule B and C facilities within a fiscal year. Reporting on unique patients means that even if a person was involuntarily/voluntarily admitted multiple times over a year, they are only "counted" in this figure once. Although it is not possible to directly compare the 2020/21 year with the previous years, we include this figure because, consistent with data from 2011/12 to 2017/2018, it shows an increase in the volume of involuntarily admitted patients over time, while the volume of voluntary patients remains steady over the years.

Figure 1a. All discharges of unique voluntary and involuntary patients from Schedule B and C facilities[63] designated under the *Mental Health Act* by fiscal year, Main Diagnosis category, 2011/12–2020/21

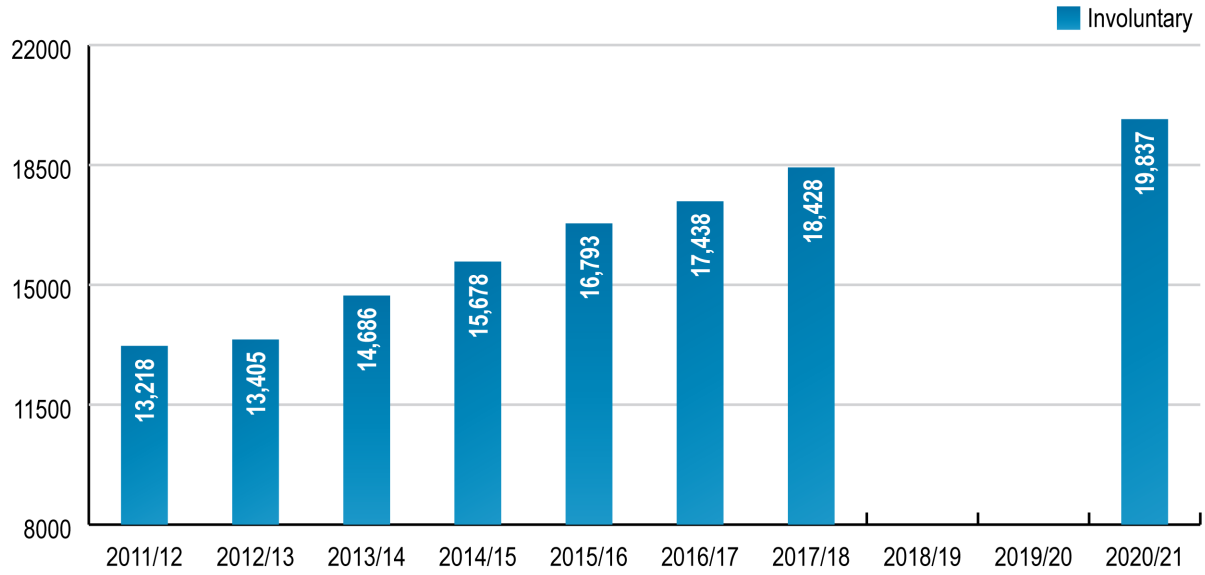


Note: *The total unique patient count for 2018/2019 is 27,890 (voluntary and involuntary patients combined) and for 2019/2020 is 28,799 (voluntary and involuntary patients combined) under Main Diagnosis category.*

[63] The data provided by the ministry for this figure included some schedule A facilities (Hillside Psychiatric Centre, South Hills Tertiary Psych Rehab Centre, and Jack Ledger patients at Queen Alexandra Centre for Children's Health) and Riverview Hospital data that we could not remove.

Figure 1b is new, and shows the involuntary patients for all three categories (Main Diagnosis, Other Diagnosis, Diagnosis Not under the *Mental Health Act*) who were discharged from Schedule B and C facilities by fiscal year.[64] This figure includes the total number of involuntarily admitted patients for all three diagnosis categories, which is approximately 2,000 more involuntary patients that were discharged in 2020/21 than those counted only under the Main Diagnosis category, shown in Figure 1a. As mentioned earlier, the other two categories (Other Diagnosis and Diagnosis Not under the *Mental Health Act)* do not have the equivalent voluntary patient information, so while Figures 1b and 2b only show the data for involuntary patients, this includes all involuntary patients found in the three categories.

Figure 1b. All discharges of unique involuntary psychiatric patients from Schedule B and C facilities by fiscal year, all diagnoses combined, 2011/12–2020/21[65]

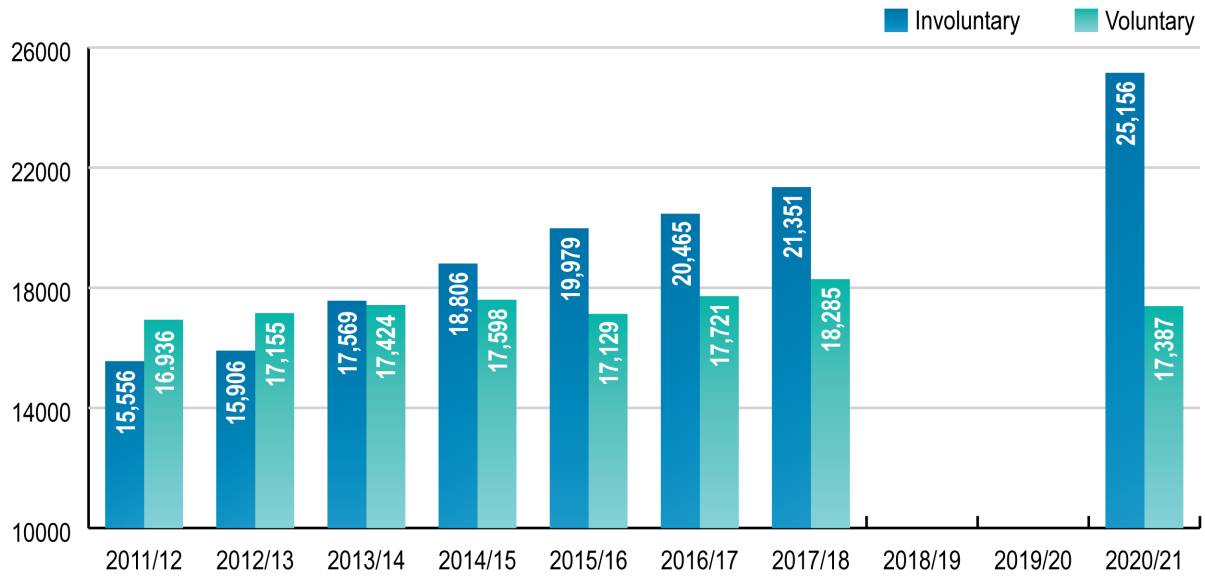


Note: *The total discharges of unique patients for 2018/2019 is 54,179 (voluntary and involuntary patients combined) and for 2019/2020 is 56,207 (voluntary and involuntary patients combined) under under all diagnosis categories.*

[64] Like Figure 1a, Figure 1b is missing data for 2018/19 and 2019/20, and includes the most recent data we have received from the Ministry of Health for 2017/18 and 2020/21.

Figure 2a is an updated re-creation of Figure 2 from the 2019 *Committed to Change* report, which includes the most recent data we have received from the ministry.[66]

Figure 2a. All discharges of voluntary and involuntary patients from Schedule B and C facilities designated under the *Mental Health Act* by fiscal year, Main Diagnosis category, 2011/12–2020/21[67]



Note: *The total unique patient count for 2018/2019 is 39,674 (voluntary and involuntary patients combined) and for 2019/2020 is 40,782 (voluntary and involuntary patients combined) under Main Diagnosis category.*

Figure 2a shows data from the Main Diagnosis category only, and it highlights some differences between counting "unique patients" and counting patients discharged multiple times within a fiscal year.[68]

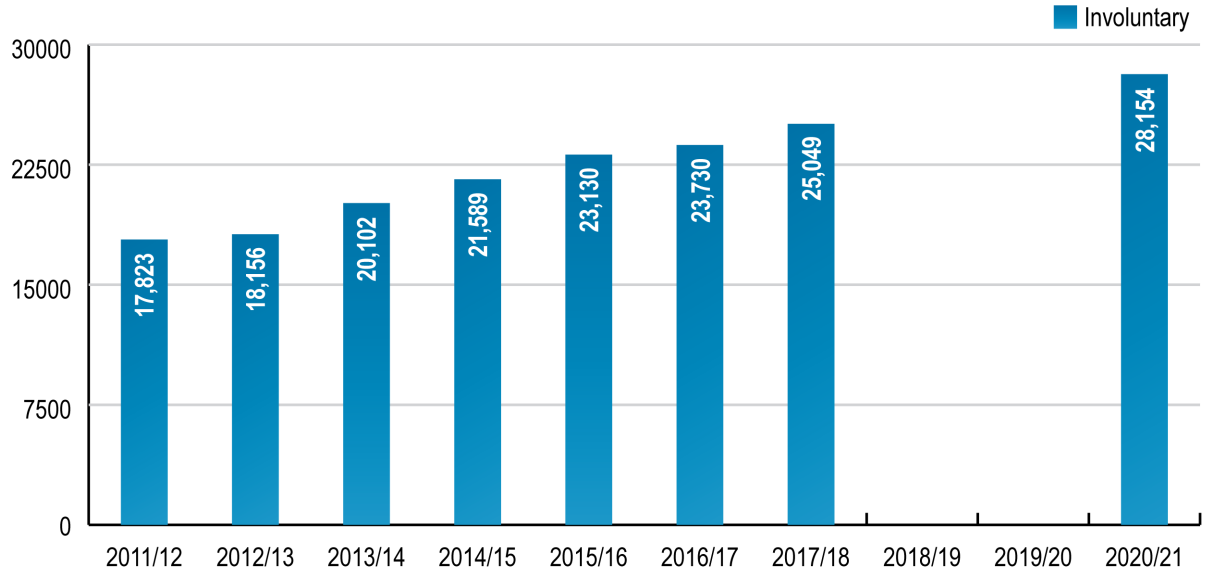
[66] This figure is also different from the original because it does not go back to 2005/06 and is missing data for 2018/19 and 2019/20.

[67] The data provided by the ministry included some schedule A facilities (Hillside Psychiatric Centre, South Hills Tertiary Psych Rehab Centre, and Jack Ledger patients at Queen Alexandra Centre for Children's Health) that we have removed from the data in this figure. In keeping with the original *Committed to Change* report, we also did not include Riverview Hospital data in this figure as this facility was closed in 2012.

[68] Once again, 2020/21 is not directly comparable with previous years because of more accurate reporting methods, but the data shows that involuntary patients are 1.4 times more likely to be admitted more than once within this year than voluntary patients. While voluntary patients were more frequently admitted multiple times than involuntary patients in 2011/12 and 2012/13, over time this pattern has shifted. Involuntary patients are increasingly admitted multiple times within a fiscal year, whereas the frequency of multiple admissions per year for voluntary patients has flattened out over time.

Figure 2b includes involuntary patients for all three diagnosis categories and shows an overall increase over time in the number of involuntary patients who are discharged from Schedule B and C facilities.[69]

Figure 2b. All discharges of involuntary psychiatric patients from Schedule B and C facilities[70] designated under the *Mental Health Act* by fiscal year, all diagnoses combined, 2011/12–2020/21



Note: *The total discharges of patients for 2018/2019 is 78,554 (voluntary and involuntary patients combined) and for 2019/2020 is 81,590 (voluntary and involuntary patients combined) under all diagnosis categories.*

[69] It also shows, in comparison with involuntary patients in Figure 2a (Main Diagnosis), that patients in the other two categories (Other Diagnosis and Diagnosis Not under the *Mental Health Act)* contribute to an increasing number of discharges per year, sometimes as much as over 3,500 additional discharges (2017/18). This highlights the importance of including all three diagnosis categories when considering involuntary patient data.

[70] The data provided by the ministry included some schedule A facilities (Hillside Psychiatric Centre, South Hills Tertiary Psych Rehab Centre, and Jack Ledger patients at Queen Alexandra Centre for Children's Health) that we have removed from the data in this figure. In keeping with the original *Committed to Change* report, we also did not include Riverview Hospital data in this figure as this facility was closed in 2012.

APPENDIX B: FORM COMPLETION DATA

The following figures indicate the presence (the patient file contained the form), completion rates (the form was fully completed), and quality of completion (the form contained all of the required information on time and was specific to the patient) for the required forms under the *Mental Health Act*. Figure 3 shows the percentage of patient files that contained (where the form was present on file) each required form for involuntary admission under the *Mental Health Act* for the most recent audit period available, combining data from all health authorities (Fraser Health, Vancouver Coastal Health, Interior Health, Island Health, Northern Health and the Provincial Health Services Authority).

Figure 3. Percentage of patient files containing required forms, by form, all health authorities, Oct–Dec 2020

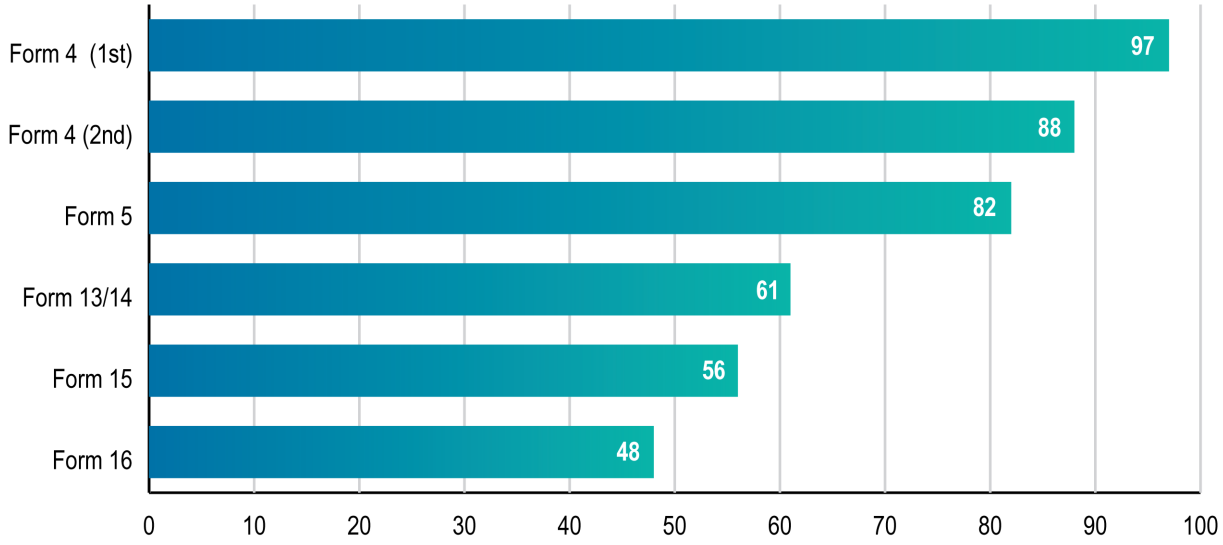


Figure 4. Percentage of patient files containing all required forms (Form 4 (1st and 2nd), Form 5, Form 13/14, Form 15 and Form 16), by health authority, Oct–Dec 2020[71]

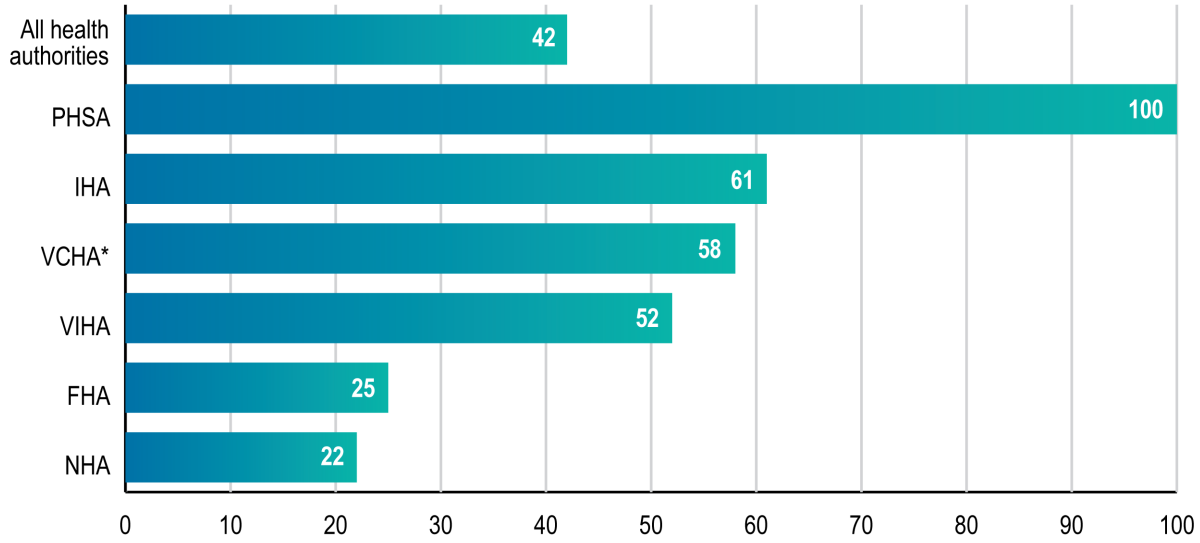


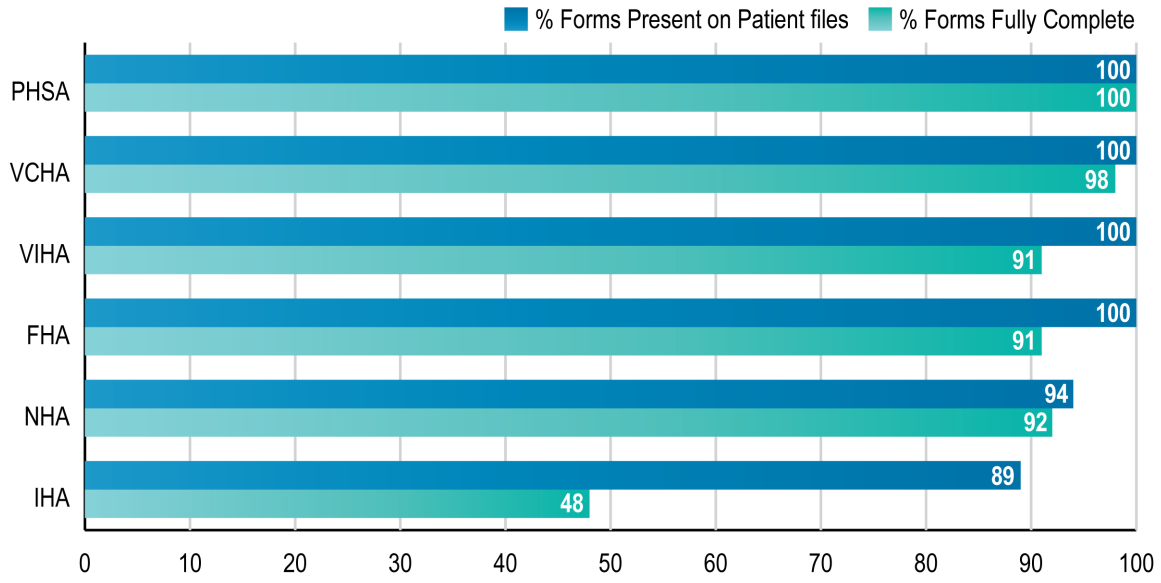
Figure 4 shows the percentage of patient files that contained all required forms (Forms 4, 5, 13/14, 15 and 16) for involuntary admission by health authority for the same audit period, and highlights significant variation in how the health authorities are meeting this standard.[72] The figure indicates that the forms were present in a patient's file, but it does not indicate to what extent they were completed or the quality of that completion.

[71] The asterisk (*) for VCHA indicates that this data includes patients admitted to St. Paul's Hospital, operated by Providence Health Care in partnership with Vancouver Coastal Health. This data was based on the audit information shared to us by the health authorities, and calculated based on the number of the "Total # Charts Audited with All Required Forms" divided by the "Total # Charts Audited" for each health authority. The ministry has informed us that the percentages are higher but it has not provided more information or explanation. As such, we have kept the figure based on the data we received, and we encourage the ministry and the health authorities to make public other data they have available.

[72] The number of charts audited for each health authority is determined by the following "formula" in the audit instructions: "Facilities with fewer than 10 eligible patients will audit all charts. Facilities with fewer than 100 eligible patients will audit 20% of all charts. Facilities with more than 100 eligible patients will audit 10% of all charts to a minimum of 20 charts and a maximum of 40 charts (or more if deemed necessary by the Mental Health Act Director of the designated facility)." The total number of charts audited for each health authority was over 100, except for the Provincial Health Services Authority (PHSA), where only 30 charts were audited – a significantly smaller sample size. Of these 30 charts, 30 Form 5s, 13s, 15s and 16s were present, although only 15 of the Form 4s (1st and 2nd) were counted. It is possible that 15 of the Form 4s were completed at another facility, and in this case the *Mental Health Act* Audit Instructions state that "Mental Health Act Directors are responsible only for forms required, attempted or completed in the facility for which they provide oversight." Therefore, if PHSA has 30 Form 4s but some of them were completed at another facility, it would still count the 30 for presence on the file, but would only examine the quality of the Form 4s that were completed by PHSA staff. This issue also arises with Island Health.

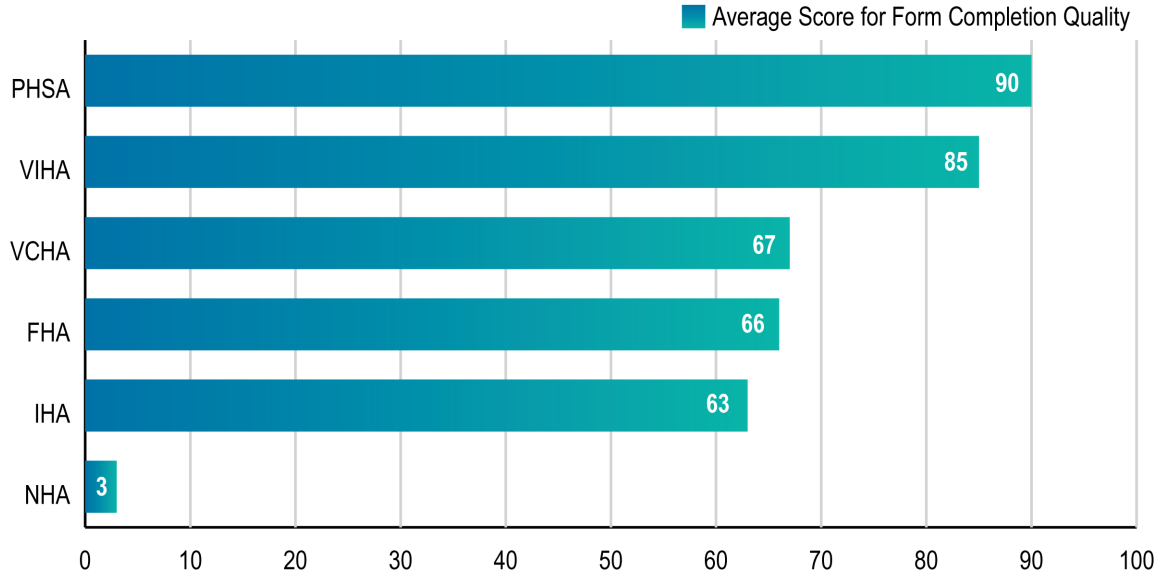
Figures 5a and 5b reveal gaps between form presence and form completion on patient files for Form 4 by health authority. Overall, there is high rate of full form completion and presence of Form 4 (1st form) for all of the health authorities, with the exception of Interior Health.

Figure 5a. Percentage of patient files containing Form 4 (1st medical certificate) versus percentage with fully completed Form 4, by health authority, Oct–Dec 2020



However, Figure 5b indicates significant gaps in the quality of Form 4 completion, particularly for Northern Health, and to a lesser extent Vancouver Coastal Health, Interior Health and Fraser Health. The quality of form completion is derived from quality indicators that are based on the provincial standards set for completing the forms.[73]

Figure 5b. Average score based on quality of Form 4 (1st) completion (quality indicators), by health authority, Oct–Dec 2020



[73] For example, quality indicators include the reasons given by the physician for involuntarily admitting the patient, legibility of the physician's writing, not using "boilerplate" language or stamps, and timely completion and dating.

Figure 6a shows the percentage of patient files that contained a Form 5 (consent for treatment) and compares this with the percentage of patient files where the consent for treatment form was fully completed, by health authority. In this case, the percentage of patient files with fully completed forms is much lower for all health authorities.

Figure 6a. Percentage of patient files containing Form 5 (Consent for Treatment) versus percentage with fully completed Form 5, by health authority, Oct–Dec 2020

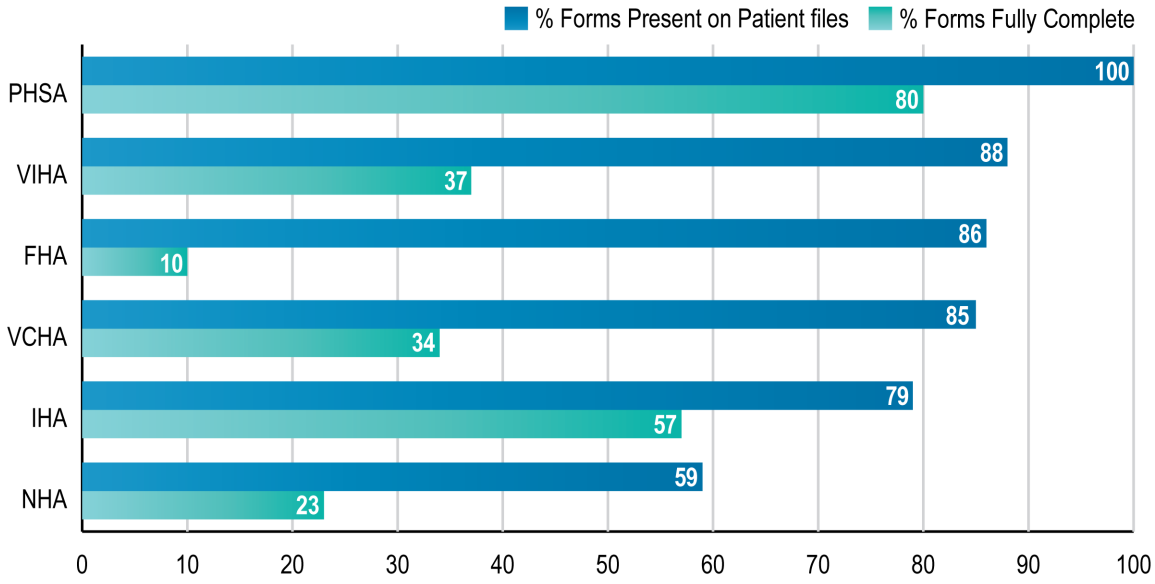
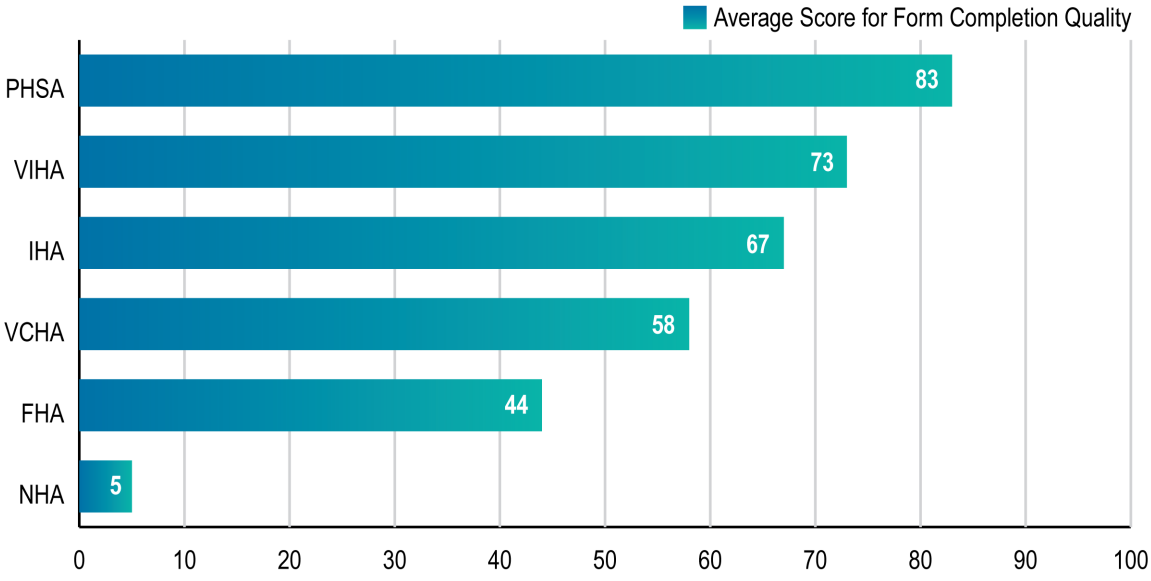


Figure 6b also highlights the fact that the quality of form completion varies among health authorities, and that the presence of a form does not necessarily mean it has been fully completed or completed well.

Figure 6b. Average score based on quality of Form 5 completion (quality indicators), by health authority, Oct–Dec 2020[24]



[74] The ministry indicated that the percentage for IHA in this Figure was 62%, but this did not match the data we received from the health authority, which is used in the figure.

Form 13/14 provides notification of rights to involuntary patients. Figures 7a and 7b provide completion and quality data for Form 13/14.

Figure 7a. Percentage of patient files containing Form 13/14 (Notification of Rights/ Notification to Patients Under the age 16, Admitted by a Parent or Guardian, of Rights under the *Mental Health Act*) versus percentage with fully completed Form 13/14, by health authority, Oct–Dec 2020

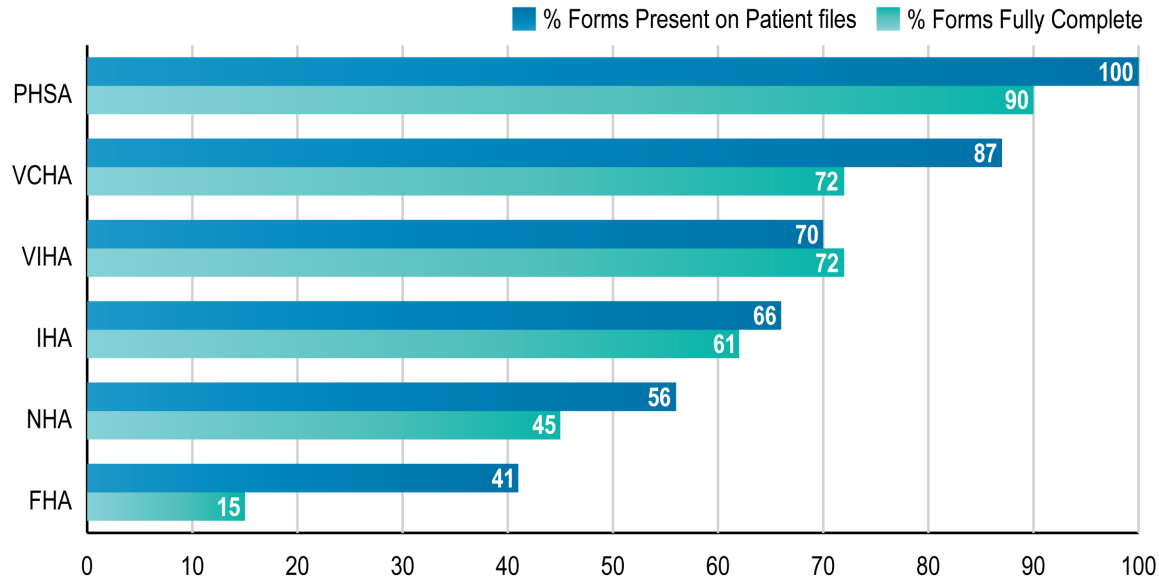


Figure 7b. Average score based on quality of Form 13/14 completion (quality indicators), by health authority, Oct–Dec 2020

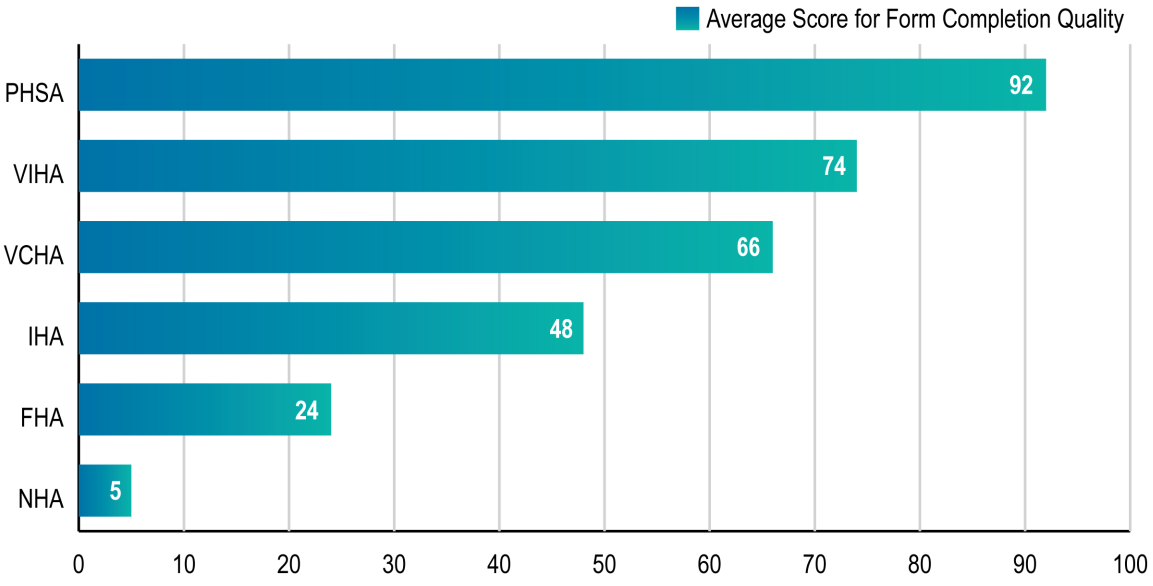
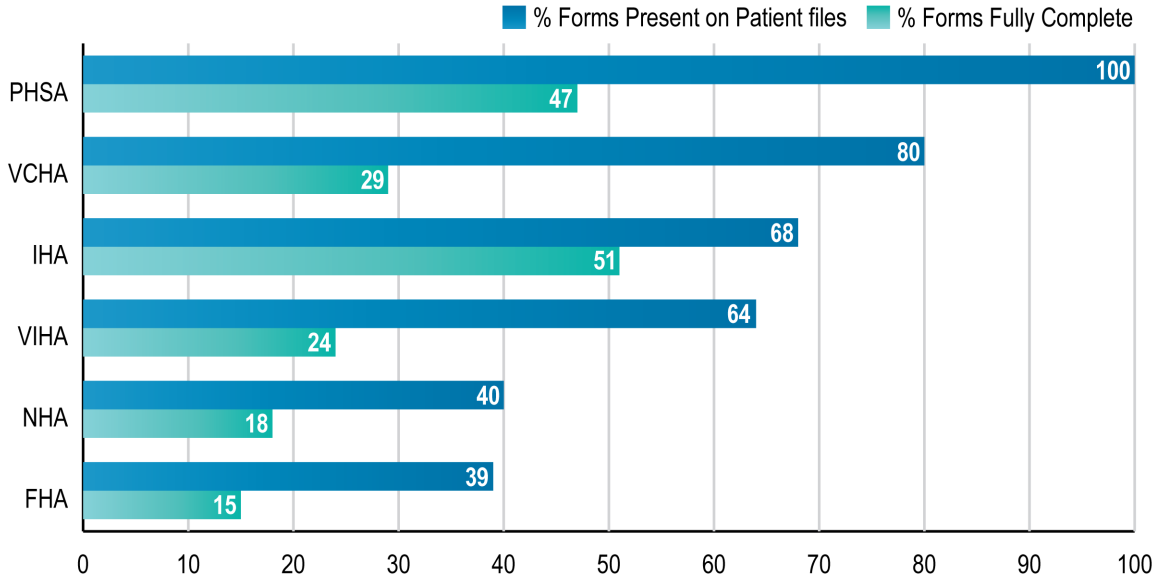


Figure 8a shows another wide discrepancy between the presence of Form 15 on a patient's file and whether that form has been fully completed.

Figure 8a. Percentage of patient files containing Form 15 (Nomination of Near Relative) versus percentage with fully completed Form 15, by health authority, Oct–Dec 2020



Figures 8b, 7b and 6b show a trend in terms of quality of form completion, where the average score by health authority remains relatively consistent, although usually with higher quality scores for Form 4 (see Figure 5b). This indicates an issue with the health authority, and not necessarily with the forms themselves.

Figure 8b. Average score based on quality of Form 15 completion (quality indicators), by health authority, Oct–Dec 2020

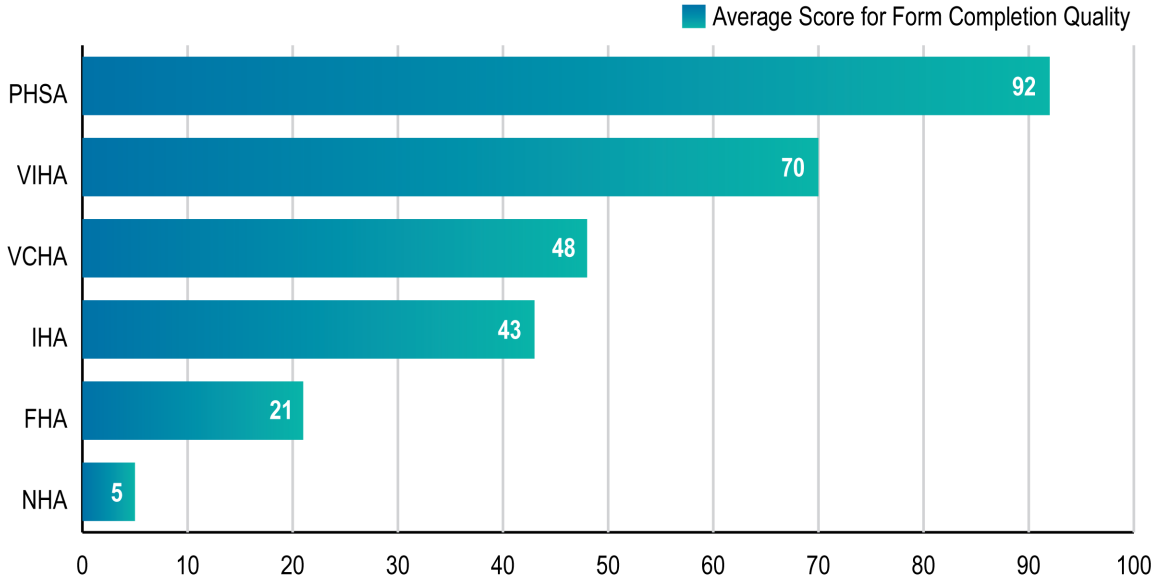


Figure 9a reveals similar trends to those in the previous figures, although with a higher form completion rate than for Form 5 or Form 15. Northern Health and Fraser Health are consistently scoring poorly, particularly for quality and completion of all forms.

Figure 9a. Percentage of patient files containing Form 16 (Notification of Near Relative) versus percentage with fully completed Form 16, by health authority, Oct–Dec 2020

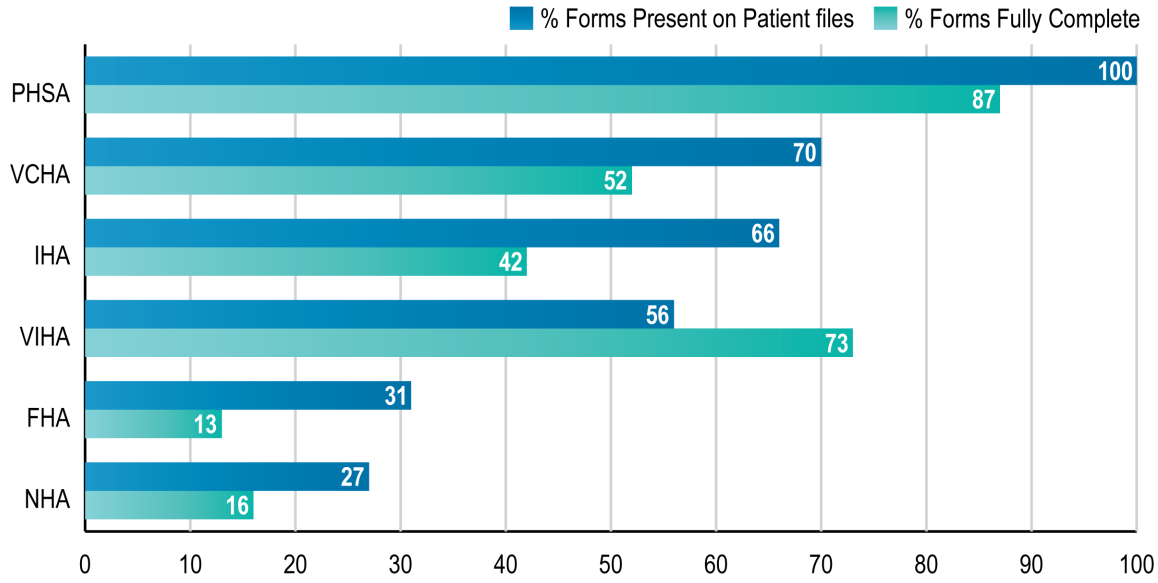
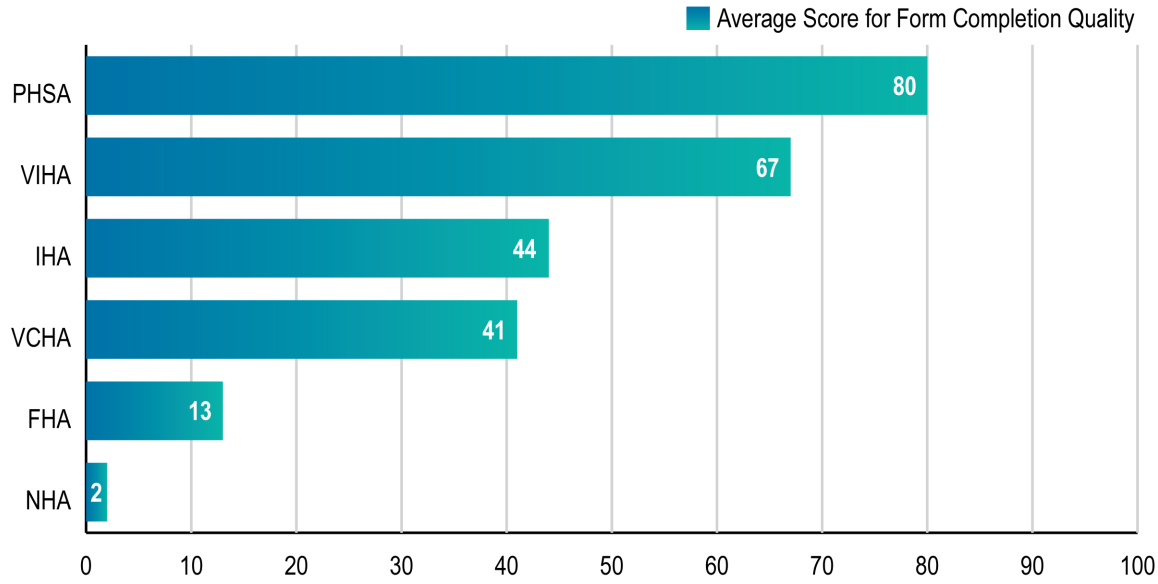


Figure 9b provides similar quality information for Form 16 by health authority.

Figure 9b. Average score based on quality of Form 16 completion (quality indicators), by health authority, Oct–Dec 2020



APPENDIX C: SOCIO-DEMOGRAPHIC DATA

The Ministry of Health collects some socio-demographic data on sex and age in relation to involuntary and voluntary patients.[75] Although we did not include this information in the original *Committed to Change* report, we have included it in Appendix C in support of our finding in the report that there was very little publicly available data about involuntary admissions and in recognition of a broader trend toward using socio-demographic data to understand differential impacts of government programs and to inform systemic changes.[76] By considering how sex and age intersect with involuntary or voluntary patient status, this data reveals disparities between involuntary and voluntary patients, between different age groups, and between female and male patients. In particular, patients in the 16–30 and 31–45 age groups are more likely to be involuntarily admitted than all other age groups (see Figures 10a and 10c). Young girls (ages 0–15) are also admitted more frequently than their male counterparts, whether voluntarily or involuntarily, but the opposite holds true for almost all other age categories (see Figures 11a and 11b). This data reveals the importance of collecting, analyzing and publishing socio-demographic data relating to involuntary and voluntary patients and raises further questions about why these differences are occurring.

Two new figures (10a and 10b) analyze the ministry's data by the age of the patients for 2020/21. We use mainly 2020/21 data because the ministry has informed us it is the most current, accurate and comprehensive data available. However, we appreciate that the COVID-19 pandemic may have impacted the data in certain ways, especially given that certain socio-demographic groups were more severely impacted by the pandemic. We encourage the ministry to assess and expand its collection and publication of socio-demographic data in line with the new *Anti-Racism Data Act*.

Unless otherwise stated, for the remaining figures in Appendix C, only data from the Main Diagnosis category is used (in order to compare voluntary and involuntary patients).

[75] The Ministry of Health currently collects data on sex under the following three categories: female, male and other. If a person identifies as neither female or male, they are counted in the total volume of patients but there is no separate data provided for patients who do not identify as female or male.

[76] See British Columbia's Office of the Human Rights Commissioner, *Disaggregated Demographic Data Collection in British Columbia: The Grandmother Perspective* (September 2020), https://bchumanrights.ca/wp-content/uploads/BCOHRC_Sept2020_Disaggregated-Data-Report_FINAL.pdf

Figure 10a highlights the fact that there are rarely any similarities between admissions of voluntary and involuntary patients by age group, with the exception of the 61–75 age group, where there are only slightly more voluntary patients than involuntary patients. The differences between voluntary and involuntary patients by age group are quite stark, particularly for involuntary patients ages 0–15, 16–30 and 46–60, and voluntary patients ages 76+.

Figure 10a. Number of unique mental health patients by age, involuntary and voluntary status, Main Diagnosis category, 2020/21

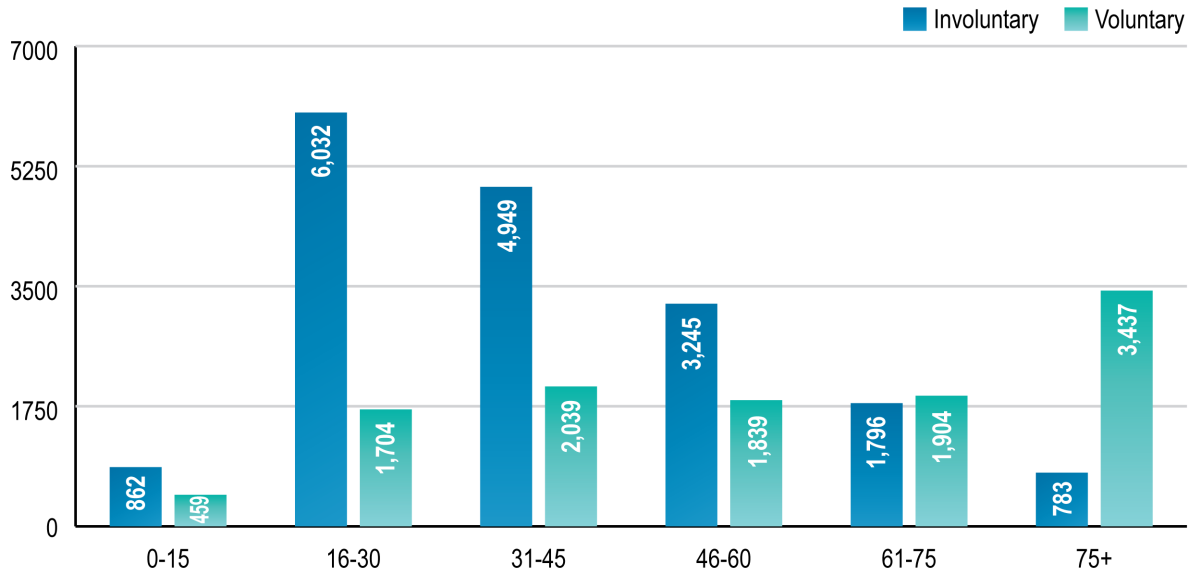
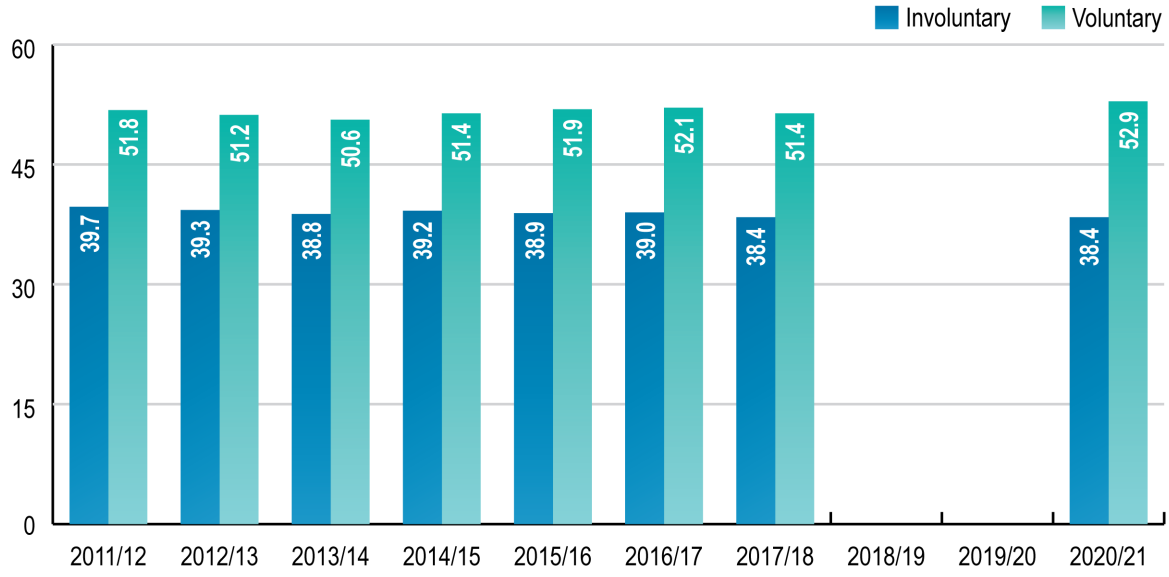


Figure 10b shows that from 2011/12 to 2020/21, the average age for people who are voluntarily admitted has been in the early 50s, whereas the average age for people who are involuntarily admitted is in the late 30s. This age difference is consistent across all of the years for which data was available.

Figure 10b. Average age of involuntary and voluntary patients with a mental health hospitalization by fiscal year, Main Diagnosis category, , 2011/12–2020/21



Note: *Data not available for 2018/19 and 2019/20.*

To make this more understandable, Figure 10c shows the age distribution of involuntary and voluntary patients for 2020/21 and reveals that the disproportionate number of involuntary patients in younger age categories (16–30 and 31–45) is skewing the average age for people involuntarily admitted downward (late 30s), whereas the greater number of voluntary patients in the 76+ age category is skewing the average age for people voluntarily admitted upward (50s).

Figure 10c. Involuntary and voluntary patients with a mental health hospitalization, by age, Main Diagnosis category, 2020/21

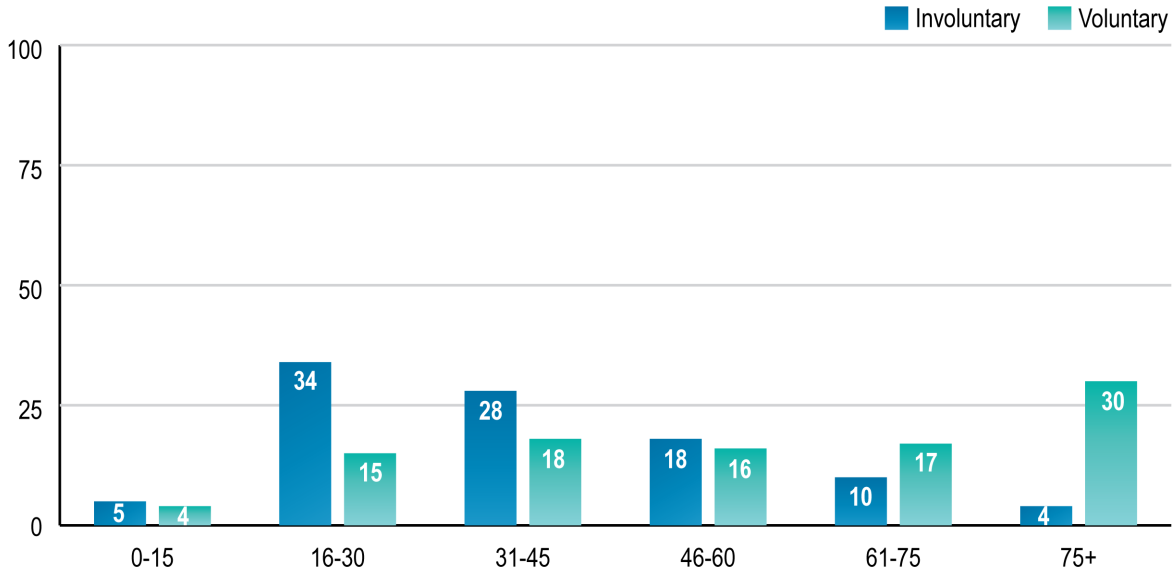
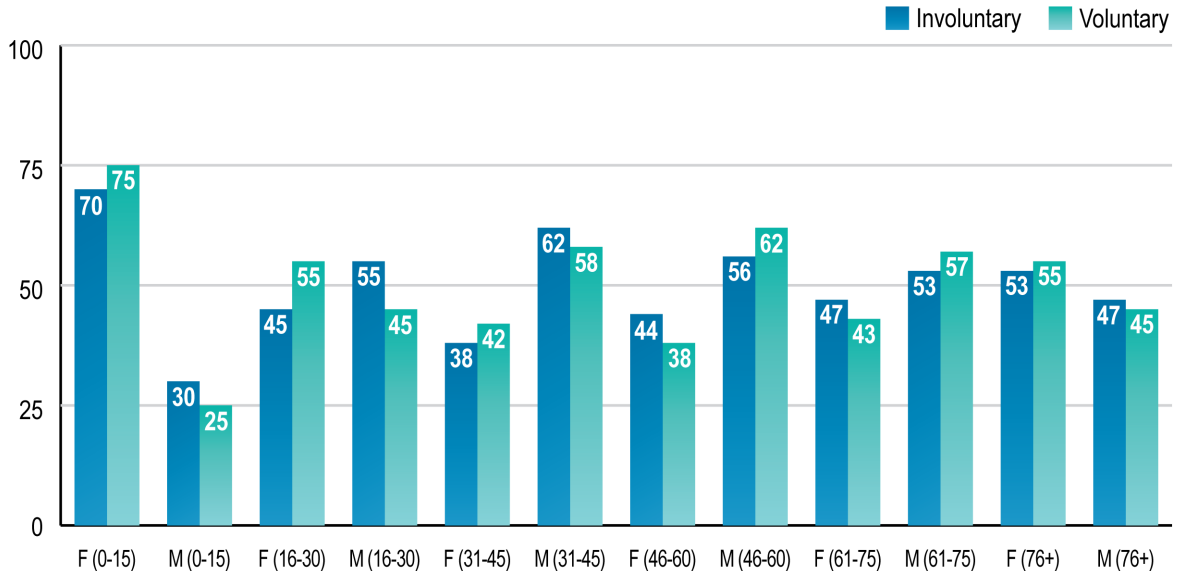


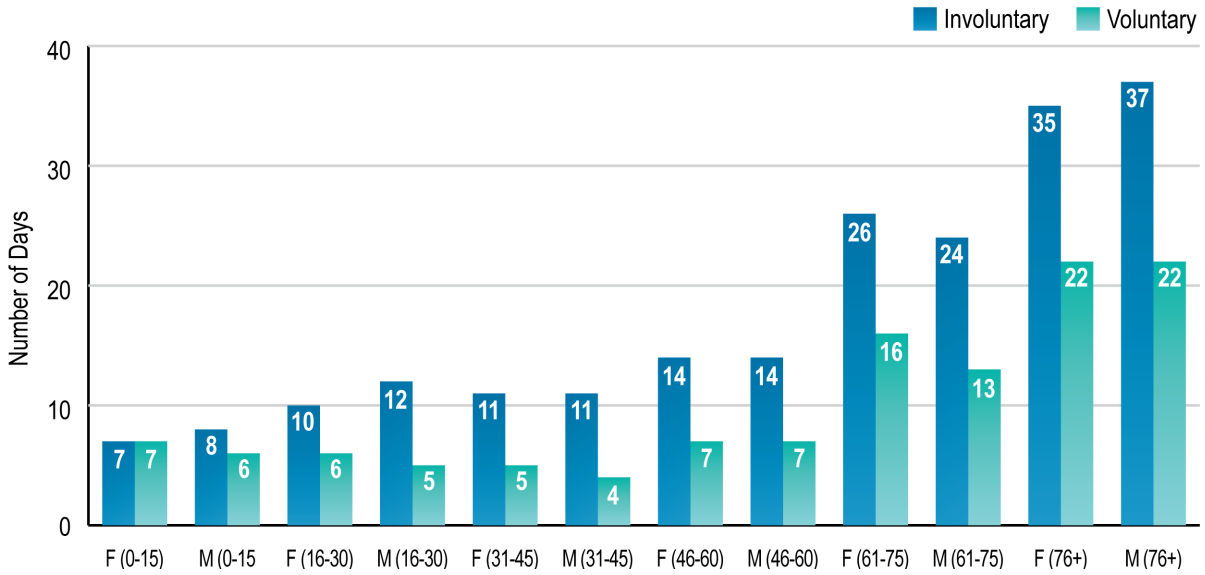
Figure 11 compares the percentages of involuntary and voluntary patients by sex and age, including data from the Main Diagnosis category only for 2020/21. This comparison reveals similarities between involuntary patients by age and sex for the older age groups (61–75 and 76+). It also reveals that a disproportionate percentage of voluntary (75 per cent) and involuntary (70 per cent) patients ages 0–15 are female. In addition, female patients ages 16–30 are more likely to be admitted voluntarily than their male counterparts, whereas the opposite is true for male involuntary patients, who are more likely to be involuntarily detained than female involuntary patients ages 16–30. Note that this figure shows only the proportion of female and male patients in each age group, not the volume of patients. As seen in Figures 10a and 10c, the volume of involuntary patients is generally higher (two to four times higher, depending on the age category) than voluntary patients.

Figure 11. Percentage of involuntary and voluntary admissions by sex and age, Main Diagnosis category, 2020/21



Lastly, Figure 12 shows the average length of stay for voluntary and involuntary patients for 2020/21 (Main Diagnosis category only). According to this data, involuntary patients, particularly from ages 16–30 onward, tend to stay longer in mental health facilities than voluntary patients, and sometimes twice as long. Within each age group and mental health status, there is little difference between female and male patient in terms of length of stay.

Figure 12. Average length of stay for voluntary and involuntary patients, by age and sex, Main Diagnosis category, 2020/21



OMBUDSPERSON

BRITISH COLUMBIA

Office of the Ombudsperson | PO Box 9039 Stn Prov Govt | Victoria, B.C. V8W 9A5
General Inquiries: 250 387-5855 (Victoria) or 1 800 567-3247 (Rest of B.C.) | Fax: 250 387-0198
www.bcombudsperson.ca