Mental Health Review Board
Mental Health Act
(section 25, R.S.B.C. 1996, c. 288)

EXCERPTS FROM PANEL MAJORITY REASONS FOR DETERMINATION, ILLUSTRATING INTERESTING LEGAL ANALYSIS OF SUBSTANTIVEISSUES AND/OR PROCEDURAL ISSUES

To protect the confidentiality of the parties these Excerpts have been altered to refer to the Patient as the "Applicant", the Treating Physicians as " Dr. XX " and the day of hearing has been redacted to show the month and year only.

Key Issues:

- **Role of Participants (Witness or Presenter?);**
- **Presence of Security as Observer;**
- **"Serious Impairment" under Statutory Criterion #1;**
- **"Requires Treatment" under Statutory Criterion #1.**

Date of Hearing: May 2020

Location of Hearing: Teleconference – Panel members, Facility Case Presenter, and Applicant/Patient's advocate at respective office locations; Applicant/Patient, Witnesses and Observer at offices of the ACT Team

Panel Members: Heather Kulyk McDonald, Legal Member & Chair; Dr. K.C. Wong, Physician Member, and Anne LeClerc, Community Member.

Case Presenter for the Facility (the ACT Team): Dr. XX

Applicant/Patient's Advocate: Mr. Dante Abbey, Mental Health Law Program, Community Legal Assistance Society

Witnesses: Ms. XX (ACT Team nurse) and Ms. ZZ (Applicant/Patient's mother)

Observer: Police Constable

INTRODUCTION

The Applicant for review is 34 years old. He has been involuntarily detained under section 22 of the *Mental Health Act* (the "Act") after his admission as a patient to the hospital ("the hospital") on June 22, 2019.

On June 22, 2019 the Patient was detained under the Act based on the assessments of two hospital physicians who each filed a Form 4 Certificate, both completed that same

day. The first Form 4 was completed by Dr. B and the second Form 4 was completed by Dr. K. Four times since then, the Applicant's statutory detention was continued by physicians completing a Form 6. The most recent Form 6 was completed on April 23, 2020 by Dr. XX, a psychiatrist and the facility's Case Presenter at this hearing. That Form 6 continued the Applicant's detention through to November 21, 2020.

The Applicant has applied under section 24 of the Act for a MHRB panel hearing to review whether his detention should continue.

We are a three-person panel appointed under section 24.1 of the Act to decide the application for review. Under section 25(2) of the Act, the purpose of this review hearing was to determine whether detention should continue because the four criteria set out in sections 22(3)(a)(ii) and (c) of the Act continue to describe the Applicant's condition. All four criteria must be met to continue the Applicant's detention.

Due to the current global health crisis involving the Covid19 virus, the review panel hearing on May 14, 2020 took place by way of teleconference. The Applicant and witnesses participated by telephone from the ACT Team offices, with a police constable present as an observer. Dr. XX, Mr. Abbey and the Panel members participated from their respective office telephones. The panel chair audio-recorded the hearing.

DETERMINATION

Based on the evidence and submissions before us at the hearing, a majority of the panel members, Ms. Kulyk McDonald and Dr. Wong, decided that on a balance of probabilities, the evidence did not prove all four criteria in section 22 of the Act continued to be met. Ms. LeClerc, the panel's community member concluded otherwise, finding that the evidence did prove, on a balance of probabilities, that all four statutory criteria continued to be met. Given the majority determination, the result was the Applicant's discharge from detention.

At the end of the hearing, after the panel deliberated in private, the panel chair verbally communicated the panel's majority decision and the dissenting opinion to the parties with the explanation that reasons would follow. These are our reasons for determination, with the majority reasons for determination provided first, followed next by the reasons for the dissenting opinion.

Procedural Issues

Dr. XX queried whether the panel members had received his Case Note with supporting documentation. The panel and Mr. Abbey confirmed they had received all this documentation in advance of the hearing.

On behalf of the Applicant, Mr. Abbey submitted that Ms. XX should be a witness rather than a co-presenter with Dr. XX because in Mr. Abbey's experience, having two facility case presenters tended to muddy the evidence, with two people then speaking over each other and out of turn, making it difficult and confusing during a teleconference to understand the evidence. Dr. XX indicated that he had no objection to treating Ms. XX as witness although he intended not to have her, as a co-presenter, jointly speaking with him; rather, he intended to ask her questions after his evidence was completed, so there should be no problem with evidence being presented in a confusing manner. In light of no significant objection by Dr. XX to Mr. Abbey's suggested way of proceeding, the panel ruled that Ms. XX would be a witness rather than a co-presenter. This procedure was also consistent with Dr. XX's plan of presenting evidence on the facility's behalf. Ms. XX would wait outside the room until called to give her evidence as a witness.

Mr. Abbey also objected to the presence of a city police officer in the ACT Team office room with the Applicant for the duration of the hearing. Mr. Abbey submitted that with the Applicant alone in the room, security concerns were unlikely and, therefore, it would suffice if the Constable waited outside the hearing room where he could enter if a security reason deemed it necessary for him to do so. Mr. Abbey further submitted that it might be "off-putting" or intimidating for the Applicant to give his testimony with a police officer in the room. Mr. Abbey stated that this would be prejudicial and unfair to the Applicant. The panel ruled that the Constable could remain in the room. It is a facility's presumptive right to decide security issues at its offices. Further, the panel was not persuaded, on a balance of probabilities, that there was sufficient evidence to support Mr. Abbey's submission that the Applicant would be intimidated by the Constable's presence or otherwise unfairly prejudiced in his ability to testify…

ANALYSIS

Criterion #1: Does the Patient have a disorder of the mind that requires treatment and seriously impairs the Patient's ability to react appropriately to his environment or to associate with others? (Section 22(3)(a)(ii) and s. 2 of the Act)

The panel majority concluded that although the Applicant has a disorder of the mind, there is insufficient evidence to prove that at this time, and for the foreseeable future, the disorder *seriously* impairs his ability to react appropriately to his environment or to associate with others. We emphasize the statutory requirement that a mental disorder be serious in nature, sufficient to justify the extraordinary restrictions of personal human rights exemplified by detention under the Act. We note that in making this finding, we

understand and accept the evidence about the beneficial effects of psychiatric medication on the Applicant's disorder. Nevertheless, even with those beneficial effects in mind, the evidence does not persuade us that the Applicant continues to meet the first statutory criterion for detention, not at this time nor for the reasonably foreseeable future…

After considering the evidence and the parties' submissions, we concluded that on a balance of probabilities, the first criterion for detention under the Act is not met in this case.

We accept that the Applicant has a mental disorder, namely, a schizoaffective disorder with disorganized thinking, as diagnosed by Dr. XX and the physicians completing the two Form 4s in 2019 that give rise to the current review proceeding. The Applicant did not seriously dispute that evidence, indicating only that from time to time he disagrees with a diagnosis of mental disorder. We find that the Applicant's insight into this condition is limited.

It is clear that sometimes, the Applicant's mental disorder has seriously impaired his ability to react appropriately to his environment or to associate with others, and that it has required treatment. It seems that he himself was aware of this in 2015 when he sought from help at a hospital for a racing brain and suicidal thoughts. Treatment was effective to resolve those serious symptoms of mental disorder at that time.

We note that there is no statutory presumption that because a person is diagnosed with a disorder of the mind, it automatically follows that this disorder always requires treatment and/or always seriously impairs the person's ability to react appropriately to their environment or to associate with others. Indeed, the statutory language in section. 22(3)(a)(ii) and s. 2 of the Act suggests the contrary, that is, it may not always be the case that a person with a disorder of the mind requires treatment and/or that the disorder seriously impairs their ability to react appropriately to their environment or to associate with others.

Further, we note that the Act's rights of periodic, consequential review of detention status illustrate the legal concept that a person may at some times fulfill all four criteria for statutory detention and yet at other times, not fulfill all of those criteria. This is so,

despite the fact that a person may have a chronic mental disorder. The Act recognizes that there may be recovery from a mental disorder, or extended periods of recovery, remissions and stability during a lifetime, even with a chronic mental illness.

The evidence in this case indicates that at this time the Applicant continues to demonstrate disorganized thinking and some delusional ideas, symptoms of his mental disorder, which Dr. XX indicates are chronically resistant to psychiatric treatments including medications. We find, however, that these residual symptoms of mental disorder do not seriously impair the Applicant's ability to react appropriately to his environment or to associate with others, nor do they require treatment. Those symptoms are resistant to treatment, and yet, the Applicant appears to be functioning in a stable way in the community.

It is likely that some persons would view the Applicant's lifestyle and presentation as eccentric and unusual, and might find his unusual ideas and theories off-putting. The evidence is that the Applicant is in the habit of sending verbose, obtuse letters to various organizations, pursuing complex lawsuits, and sometimes engaging in wild verbal tirades at mental health personnel. He is also often dismissive, sarcastic and rude with the ACT Team members. As some of the treating psychiatrists have observed, it can sometimes be difficult to follow the Applicant's train of thoughts. However, Canadian society is democratic and reasonably tolerant, such that its citizens are expected to accept and find ways to deal with a wide range of diverse behaviours that may be challenging and even a degree offensive to some people. Such behaviours, in order to support justifiable detention under the Act as "serious" impairments to a person's ability to react appropriately to their environment or to associate with others, must go beyond mild nuisances and annoyances. Further, mental health professionals may expect to deal with a somewhat higher degree of behavior that falls into the categories of nuisance and rudeness.

The evidence about the Applicant's behaviour at this time, and for the last year, falls short of satisfying us, on a balance of probabilities, that his ability to function with others in his environment is seriously impaired by his mental disorder. He is living independently with roommates who are supportive of him. He has a good relationship with his mother, Ms. ZZ, who sees him regularly and keeps in contact with him. She listens to his interesting theories and ideas, too, and does not seem to be bothered by them. His family helps him financially by paying his cell phone bill for him. He is able to pay his rent and, apparently, purchase recreational drugs. There was a lack of supportive evidence to indicate that the Applicant is a trouble-maker in his community, either with his landlord or involved in arguments or physical altercations with merchants, neighbours or others in the community. He is not homeless and the evidence did not indicate a history of homelessness. He is able to feed himself. We acknowledge the evidence that sometimes he phones to ask the ACT Team for free food, but do not find that this proves he is unable to feed himself. We find it likely free Subway sandwiches would attract many persons who are nonetheless able to afford their grocery bills. His mother Ms. K, who has known him for over twenty years and sees him on a regular basis,

believes him capable of taking care of himself. He denies suicidal thoughts and his mother does not perceive him to be suicidal.

We note that virtually all of the Applicant's hospitalizations since 2016 were because of his non-compliance with psychiatric medications – promptly, before any evidence of mental deterioration, the Applicant was picked up on a recall order and taken to hospital. The one exception was in July 2018 when his treating psychiatrist at the time noticed a higher degree of mood and flight of ideas, suggesting some mental deterioration below baseline. That prompted the psychiatrist to recertify the Applicant with a further hospital admission. For the last four years, there has not been a lengthy period of time in which the Applicant has been decertified with evidence of resulting substantial deterioration in his mental condition such that he was seriously impaired in his interactions with his environment or others.

Indeed, the only evidence of serious, notably negative behavior by the Applicant was after his recertification in July 2018 and after his admission to hospital and medicated with Abilify. The initial hospital intake report referred to agitation and verbal hostility arising from the Applicant's anger about being hospitalized. The Applicant's subsequent anger and threats were related to his anger at the mental health system and mental health professionals. We find that this suggests not a symptom of a seriously deteriorating mental disorder but rather a symptom of his outrage at being recertified and admitted to hospital. He was seriously angry and obviously made serious verbal statements. However, it is not what people say that counts – it is what they do. We note that despite his outrage, the evidence does not support a finding that the Applicant actually made any attempts to physically hurt anyone, nor did he attempt to hurt himself. He was very agitated and upset, which justified the decision to help him settle by treating with Accuphase and seclusion.

We acknowledge that the Applicant has been medicated almost consistently for the last four years apart from one five-month period in which he apparently secretly stopped taking Abilify. The evidence does not support a finding that during that five-month period, the Applicant's mental condition deteriorated such that he was seriously impaired in his ability to react appropriately to his environment or with others. Despite that almost consistent medication for several years, the Applicant's delusions and disorganized thinking persists, but he remains stable living in the community. There is insufficient evidence to conclude that, at this time and for the foreseeable future, if decertified and without medication, the Applicant would likely attempt suicide, harm himself, harm others or become a significant nuisance to society. Further, the evidence is insufficient for us to conclude that the Applicant would be unable to look after himself or otherwise be unable to react appropriately to his environment or to react with others.

Therefore, on all the evidence, on a balance of probabilities, we conclude that at this time, the Applicant's mental disorder does not seriously impair his ability to react appropriately to his environment or to associate with others. For the foregoing reasons, we find that at this time, the first criterion under Section 22(3)(a)(ii) and s. 2 of the Act is not met in this case.

Criterion #2: Does the Patient require treatment in or through a designated facility? (Section 22(3)(c)(i) of the Act)

Given our finding on the first criterion, this issue is moot. We will address it only briefly.

Referring to our reasons on the first criterion, we are not satisfied that at this point in the Applicant's life, he needs intensive and consistent medical/psychiatric support. In fact, the evidence is clear that apart from his reluctant acquiescence in complying with oral psychiatric medications dispensed at the local pharmacy, the Applicant is barely engaging with the ACT Team. This has been the case for some months. We believe it likely that in a matter of time, he will also stop taking psychiatric medications in any event. It is also clear that the Applicant continues to display a significant degree of delusional thoughts and disorganized thinking, despite psychiatric medications, and that these symptoms are not seriously hampering his ability to function tolerably well in the basic activities of daily living.

We rely on our earlier reasons that the evidence does not support a finding, on a balance of probabilities, that it is likely if unmedicated, the Applicant will make a suicide attempt, attempt to hurt someone else, or experience a serious deterioration in his lifestyle. There is always the potential for such risks, but we find that the evidence at this time indicates they are not likely to happen. There is also a risk, of course, that the Applicant may ultimately seriously deteriorate into a state of extreme mania and that such a decompensation may make it more difficult to stabilize him to a baseline state of tolerable delusions and disorganized thinking. We do not find, however, on a balance of probabilities, that such a risk is probable at this time, justifying continued statutory detention as outweighing the Applicant's desire and right to an opportunity for liberty. This is particularly so, given that the risk of such serious deterioration is less in the presence of a supportive family who are in regular contact with the Applicant and who would likely recognize early signs of deterioration. Ms. ZZ presented as a credible witness who indicated that she would seek appropriate help for the Applicant if she became aware of such a need.

Therefore, we find that on a balance of probabilities, the second criterion is not met in this case, at this time.

Criterion #3: Does the Patient require care, supervision and control in or through a designated facility to prevent his substantial mental or physical deterioration or for his own protection or for the protection of others? (Section 22(3)(c)(ii) of the Act)

We found that this third criterion was also not met in the Applicant's case at this time.

We note that Dr. XX was unable to state with any reasonable degree of probability or certainty that if decertified and unmedicated, the Applicant's mental disorder would deteriorate significantly in the reasonably foreseeable future. He noted that the degree

of decompensation and the time in which it would take for a serious deterioration to result, was a challenge for him to assess. In effect, he had no answer which would support a finding that on a balance of probabilities, the Applicant's mental or physical condition would seriously deteriorate in the reasonably foreseeable future such that recertification under the Act would be necessary to protect the Applicant, others or to prevent the Applicant's substantial mental or physical deterioration.

We also refer to the presence of family support in the Applicant's case which we find is sufficient, at this time and in the foreseeable future, to be a reliable source of care, supervision and control that would prevent the Applicant's substantial mental or physical deterioration, and that would protect him and others (although the evidence does not indicate the Applicant is a risk to others in the community).

In this regard, we note the testimony of Dr. ZZ that it would not be unreasonable to expect that with reliable family support, the Applicant could manage in the community while decertified.

The evidence satisfies us in this case that the Applicant has adequate family support that would prevent substantial mental or physical deterioration, or harm to himself or others.

Therefore, for the foregoing reasons, we find that the third criterion for statutory detention is not met in this case, on a balance of probabilities.

Criterion #4: Can the Patient be suitably admitted as a voluntary patient? (Section 22(3)(c)(iii) of the Act)

Again, although a moot issue given our other findings, we conclude that the fourth statutory criterion was met in this case.

Briefly, we find that the overall evidence proves, on a balance of probabilities, that at this time and for the foreseeable future, the Applicant would be unlikely to cooperate with any psychiatric medication or engage in psychiatric treatment. He has some insight into his mental disorder but sees no benefit in psychiatric medication. In his view, the side- effects outweigh the benefits. He is hostile toward the mental health system and mental health professionals. Until this attitude changes, he would not be a suitable candidate as a voluntary Applicant.

Therefore, we found that the fourth statutory criterion was met in this case, at this time.

CONCLUSION

We conclude, on a balance of probabilities, that not all of the four criteria set out in section 22(3)(a)(ii) and (c) of the Act continue to describe the Applicant's condition. Having reached that conclusion, and pursuant to section 25(4.1) of the Act, we find that the Applicant must be discharged from involuntary detention.

Digitally signed by two members of the Review Panel, Heather Kulyk McDonald (Legal member) and Dr. K.C. Wong (Physician member)

Those two Panel members acknowledge that the foregoing Reasons reflect their decision and have authorized Heather Kulyk McDonald to sign on their behalf.

Heather McDonald, Legal Member

DISSENTING REASONS OF ANNE LECLERC, COMMUNITY MEMBER

ANALYSIS by the Dissenting Member

Criterion # 1: The patient has a disorder of the mind that requires treatment and seriously impairs the patient's ability to react appropriately to their environment or to associate with others (s. 22(3)(a)(ii) and s. 1 of the Act)

This Review Panel member found that this criterion was **satisfied** based on the following evidence.

What is the mental disorder?

- The Applicant has been known to mental health services since 2015 with an established diagnosis of schizoaffective disorder with comorbid cannabis use disorder and cocaine disorder.

What are the symptoms?

- Chronic delusional beliefs with thought disorder and disorganized behavior in addition to history of elated mood, grandiose delusions, and pressured speech, suggestive of manic episode.
  - The Applicant has most recently been on extended leave since July 15, 2019 following his discharge from hospital. He has had 5 hospitalizations (July 2015, Aug-Oct 2015, Nov 2015, July 2018, June-July 2019) and 5 recalls [Nov 2015 (subsequently hospitalized), Feb 24, 2016 (ER visit only), April 12, 2016 (ER visit only), July 19, 2018 (subsequently hospitalized), June 22, 2019 (subsequently hospitalized)].
  - He was unsuccessful in obtaining decertification in a previous review board hearing.

- Poor engagement with the treating psychiatrists and mental health teams persists and it is reported by the case presenter that there is an apparent lack of motivation to reduce or stop using drugs.
- In an appointment on Nov 21, 2019, according to the case presenter, the Applicant talked about fantasy gardens and that this is proof of time travel. On Jan 9, 2020, he continued to take about the "truth". The case presenter's notes point to a level of disorganization in his thinking. On March 6, 2020, it is reported he was very dismissive and sarcastic during an interaction with a senior resident physician. On March 17, 2020, he was irritated, agitated and raised his voice when the case presenter attended to his home with the police as a follow up to the letter he had sent to the police. On April 23, 2020, the case presenter reports he was very dismissive during their pre-arranged telehealth visit and ended the conversation quickly.
- There is a pattern to the hospital admissions and a risk of being hospitalized again if decertified.

What evidence is there of serious impairment in the patient's ability to react appropriately to his environment or associate with others when untreated/unwell?

- His treating psychiatrist states the Applicant has ongoing lack of insight into his mental illness and need for medications and will discontinue his medications if decertified. There is evidence that when he is untreated or unwell, his ability to function in the community is impaired – when recalled and admitted to hospital in June of 2019, it was reported he had not eaten for 2 days; there is risk of self-neglect. There has been suicidal ideation in the past. There is a risk of an escalation of drug use when unwell/manic. He has displayed agitation and has verbally threatened mental health staff in the past when unwell. It has been reported that the Applicant exhibited poor tolerance for boundary setting or disagreement with mental health staff which may affect his ability to react appropriately to others.

Criterion # 2: The patient requires treatment in or through a designated facility (s. 22(3)(c)(i) of the Act)

This Review Panel member found that this criterion was **satisfied** based on the following evidence.

What is the treatment?

- Treatment includes daily oral psychiatric medications: Clozapine and Lithium; daily oral non-psychiatric meds: Bisoprolol (for hypertension) and a sennoside.

- Treatment includes regular psychiatrist assessment/follow-up and NW ACT team mental health staff follow-up and support/assistance.

Has the Applicant improved with treatment? **Yes.**

- The Applicant has improved with treatment. The evidence presented at the hearing is that the Applicant is more stable than when discharged from hospital in July 2019, and also when compared to the previous 4 years (2015-2019). There have not been any hospitalizations since the July 2019 discharge. He has been living in the city for about a year and has roommates. The Applicant reports he has no difficulty with rent payments and does not have a criminal record. He agrees he participates with mental health "under protest". He is opposed to his detention and does not believe in antipsychotics.

Treatment includes supervision. Does the Applicant require supervision? **Yes.**

- Treatment includes daily dispensing of medications by a local pharmacy with witnessed ingestion of medications. Treatment includes psychiatrist assessment (currently phone follow-up) and overview from the ACT Team. Previous to his move to the city in July of 2019, he had been followed by a different suburban ACT team (April 2016-June 2019).

What kind of care and supervision is required for treatment and must it be provided in and through a facility?

- Treatment is supervised by the ACT Team, which manages Applicants with chronic and persistent mental illness that have a history of poor engagement with mental health follow up resulting in several hospitalizations. We heard evidence that the police constable is present at the ACT team location for today's hearing **"for security reasons"**.

What supports does the Applicant have in the community to provide the necessary level of care and supervision?

- The Applicant has a stepmom who does not live with him but who provides some support. The evidence presented by the stepmom indicates the Applicant has not shared past thoughts of suicidal ideation with his stepmom. The stepmom's involvement includes weekly phone calls and a once a month in-person interaction. It is unclear to this review panel member if the stepmom would be sufficiently present to observe any significant deterioration or assist the Applicant in a timely fashion if this occurs. The stepmom

supports the Applicant in his belief that he does not need the medications. She states "it's about time he's off meds…….on too long".

- The Applicant has several roommates but their ability to assist him in recognizing any significant deterioration is unknown. The case presenter was not able to verify what kind of assistance the roommates would be able to provide to the Applicant. It appears the roommates support the Applicant being off his meds.

Criterion # 3: The patient requires care, supervision, and control in or through a designated facility to prevent their substantial mental or physical deterioration or for their own protection or for the protection of others (s. 22(3)(c)(ii) of the Act)

This Review Panel member found that this criterion was **satisfied** based on the following evidence.

What is the nature of the required care, supervision and control?

The nature of the required care, supervision and control has been described above and includes the specialized services of the ACT team.

What evidence is there to show the Applicant's physical or mental condition will ***substantially*** *deteriorate without care, supervision and control?* **Described below.** *How severe is the expected deterioration?* **Significant***. What are the consequences?* **Described below.** *Are there long-term risks?* **Yes.**

- The case presenter reports there is an increased risk of self- harm without care, supervision and control: the Applicant is at risk of developing suicidal thoughts during a manic episode. The Applicant has expressed depressive episodes in the past with suicidal thoughts.
- The case presenter indicated that if untreated, he expected the Applicant's grandiose delusions and mania to return/amplify, though he could not elaborate about the expected speed of the mental deterioration. He pointed out that with the manic episodes comes an increase risk of impulsivity which could put the Applicant "in difficult situations".
- The case presenter mentioned without care and supervision, he worries about worsening psychosis, isolation, neglect, possible physically aggression, increased suicidal ideation and increased substance abuse, which could occur alongside the increase in his delusional ideas. There was evidence of increased risk of neglect presented by the case presenter – during the last hospital admission, it was reported that the Applicant had not eaten for 2 days, prior to admission. He has threatened to harm others, though there

have not been any reports of physical aggression; however, it is more likely to occur if he becomes manic or increasingly psychotic due to non-compliance with treatment. The verbal threats have been directed at mental health staff and there are no reports known of threats to others in the community at large or towards family. The resentment is towards mental health staff.

- The case presenter worries that without care, supervision and control, the Applicant would not seek out help on his own and "may not return to previous baseline".

How many past admissions have there been? **Five***. Reasons?* **Described below.** *Is there a pattern?* **Yes***. Is there a risk of being hospitalized again?* **Yes.**

- Hospital Admission – out of province July 2015 – **for just over 2 weeks.** Was described as having bizarre religious beliefs, grandiose delusions and thought disorder.
- Lower mainland BC hospital - Aug 31, 2015 – **for two months** – discharged on Oct 26, 2015. Admitted fears that people were following him. Unusual thoughts about death and re-birth. Religious belief that he was Jesus. He reported suicidal ideas prior to admission.
- Hospitalized for **one week** in November 2015. (unsure of hospital)
- Local suburban hospital, July 20, 2018 – **(length of stay unknown).** Quite elated and irritable but with no physical threats, though there was swearing and frustration with nursing staff. Pre-occupied about his grand 'equation". Difficult to follow his line of thinking or writing.
- Local suburban hospital, June 22, 2019 – **for 3 weeks** – discharged on July 15, 2019. Found to be non-compliant with his meds for a period before he was recalled to hospital. In hospital, found to be manic with grandiose beliefs.

Is there evidence of past non-compliance resulting in deterioration and /or hospitalization? ***Yes.***

- There is evidence of poor engagement with mental health follow-up resulting in several hospitalizations.
    - He did not take his medications after his discharge from hospital in July 2015. Subsequently, he was admitted to a BC hospital one month later. He had reported low mood and suicidal ideation on admission. He was discharged on extended leave but due to his disengagement was recalled at least 3 times: Nov 2015 (hospitalized), Feb 24, 2016 (ER visit), April 12, 2016 (ER visit).
    - Recalled July 19, 2018 due to "disorganized and tangential thoughts, pressured speech with flight of ideas". Erratic compliance with his medications and increased cannabis use and cocaine use. Clear deterioration in his mental status from his chronic baseline noted by the psychiatrist. Hospitalized.
    - Recalled June 22, 2019 due to non-compliance with meds. Hospitalized.
    - There is some evidence of non-compliance with appointments also.

Is there a history of assaultive or threatening behavior when ill? **Yes.**

- During the last hospitalization (June 22, 2019 to July 15, 2019), he required the seclusion room initially due to his irritability and "in fact required Acuphase IM injection due to intensity of this behavior". He was transferred to the high intensity unit due to safety concerns prior to restarting his meds.
- In an appointment with his treating psychiatrist on Nov 21, 2019, it is noted by the psychiatrist that the Applicant shared his belief that attacks on healthcare staff by Applicants are justified as Applicants are just expressing their frustration with being in hospital.

What evidence is there of symptoms and/or behaviours that put the Applicant and others at risk?

- In 2017, periodic irritability towards staff and concerns about aggression persisted, although there was no physical aggression in 2017. He was quite hostile towards a psychiatrist and he allegedly threatened to skin him alive and crucify him.
- The Applicant has been threatening to staff in the hospital setting.
  Home visits are accompanied by a police officer. The review panel hearing at the ACT Team clinic required the presence of a police officer. The Applicant sent a letter to the police chief in March 2020, though the Applicant could not explain the intent of the letter to his advocate or to the panel members.

Criterion # 4: The patient cannot suitably be admitted as a voluntary patient (s. 22(3)(c)(iii) of the Act)

This Review Panel member found that this criterion was **satisfied** based on the following evidence.

What does the Applicant say about continuing treatment if given the choice?

- The Applicant has affirmed he will discontinue his medications if decertified. He is not willing to receive treatment on a voluntary basis.

Does the Applicant have a plan for relapse? **Unclear.**

Overall, the dissenting member prefers the evidence presented by the case presenter at the hearing, over the evidence presented by the Applicant and the witness, as it is supported by the medical documentation over the past 5 years, which includes medical observations, input and analysis from numerous psychiatrists and treatment teams spanning a variety of hospital locations, some in B.C. and some in another province. Some of the Applicant's answers to the questions posed to him during the hearing were difficult to follow and

understand and supported his treating psychiatrist's evidence that the Applicant has ongoing limited insight into his disorder of the mind and need for treatment. The panel member remains concerned about the Applicant's safety and the safety of others if decertified.

This review panel member agrees with the case presenter and the facility that the Applicant continues to meet all four criteria for involuntary admission under the Mental Health Act.

This review panel member assessed, on a balance of probabilities, whether there is significant risk that the Applicant, if discharged, will as a result of his mental disorder fail to follow the treatment plan his psychiatrist considers necessary to minimize the possibly that the Applicant will again be detained under s.22 of the *Act*. This review panel member considered all reasonably available evidence concerning the Applicant's history of mental disorder, including hospitalizations for treatment and compliance with treatment plans following hospitalization. s.25(2.1) of the *Act.*

Respectfully submitted,

Anne Leclerc, Community Member, MHRB

May 2020