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Unprofessional faddism can end in tragedy

Some faddish notions that keep reappearing in psychiatric practice can end in tragedy.

Many service providers are nevertheless wedded to them, with often disturbing consequences.

Family members might express concerns, but rarely make much headway where such ideas have a hold in the service provider's mind.

One of these recurring notions is the need to establish a relationship of trust with the patient.

Developing a connection with patients is a good in itself. It's particularly important in the post-discharge phase when the patient is stabilized and the work of managing the illness proceeds. Indeed, every contact with a patient, no matter how seemingly routine, should have an element of a relationship to it rather than being mechanical or offhand.

When the establishment of a relationship is allowed to take precedence over critical clinical need, however, the psychiatrist is inviting trouble.

Here is an actual case history of what happens when this elementary clinical reality is glossed over:

A young man in North Vancouver is delusional. The system doesn't catch him and he deteriorates. Eventually, however, in an agitated phone call to his family, he gives the game away. He discloses that he is the only person in the world who can save the planet from global warming, because he is in touch with the Creator by way of a transistor inserted in his left thigh.

The mother urges Community Psychiatric Services to take action. They send out a team, but the psychiatrist astonishingly doesn't commit the ill young man. Not too long after, he is found dead at the foot of Lynn Creek, with injuries consistent with a fall from a considerable height. The death is officially attributed to misadventure.

The psychiatrist involved in the case calls the mother to explain. He tells her that he thinks he made the right decision in the circumstances because he felt he had time to develop a relationship of trust with her son. He ignores, or doesn't mention, that psychosis indicates a severe illness that needs to be treated – and treated without delay – and that, in any case, supposed relationships of trust are swept away by the power of psychosis.

He also ignores the intent of the Mental Health Act, where committal is called for to "prevent the person's substantial mental...deterioration."

The young man is dead, a death that need not have happened, but the psychiatrist's conceit about building relationships is still intact.

Notion of "trust" misapplied in other harmful ways

Giving precedence to the establishment of trust in a patient regardless of context interferes with clinical common sense in other ways, too – ways that ultimately betray the patient.

Often, for example, service providers will refuse to share information with family members because, as they explain, their patient hasn't given them permission to do so.

When they're told that under privacy legislation in BC, they are nevertheless allowed to share information with family members in these situations – something they should have known all along – they still demur.

"If I brought you into the loop without getting permission," they'll say, "I wouldn't have the patient's trust any longer."

Even when the patient's objection to sharing information with their family is based on paranoid delusions, clearly indicating a lack of insight and understanding, the service provider may stubbornly refuse to budge.

What's wrong with this? Just about everything.

Family involvement produces better outcomes. The sharing of information with family members is essential to that involvement. Blocking the flow of information to family members and not getting their feedback is deficient clinical practice, harmful to the patient and often dangerous in its consequences.

Citing the need to establish or maintain a relationship of trust with the patient should never arise in the first place when it comes to sharing information with families.

In acute care psychiatric wards and in mental health teams, information is shared freely among psychiatrists, nurses and other team members working with the same patient. Nobody asks a patient – least of all a psychotic, paranoid patient – for permission to share that information, nor is the need to maintain a "relationship of trust" ever mentioned as an excuse for not sharing.

If one includes family members as integral participants in the treatment team, as one should, then information should be shared with them in the same way. Sharing should be assumed.

There is no breaking of trust where clear and established practice is being followed.

Where family members are figures in a patient's paranoid delusions, and disclosure that the psychiatrist is talking to family members may add fuel to the paranoia, there is a provision in the Freedom of Information and Protection of Privacy Act (FIPPA) allowing for non-disclosure, exactly for such situations.

The relevant FIPPA section is 33.1(1)(m)(ii) – that disclosure to the patient isn't required if it "could harm someone's health or safety."

It's precisely when a patient is psychotic and paranoid, and likely to object to information being shared with family members if asked, that keeping family members fully informed and getting their feedback is most important.

Good psychiatric practitioners share information with family members as a matter of course and manage objections if they arise. They know that informed family involvement is an indispensable element in producing the best possible outcome, which is their first duty.

The most important "relationship of trust," when it comes to the mentally ill derives from the implicit assumption that mental health services will adhere to best practices and common sense. By not sharing information with family members, that trust is broken and the patient is betrayed.

For tragedies and other harm to the patient that occur when information isn't shared with family members, please see the Information Sharing page on the NSSS website at www.northshoreschizophrenia.org/Sharing.htm and click on "Case histories."

Coming in the next issue of the NSSS Advocacy Bulletin

The best way of "respecting the dignity" of the mentally ill is by ensuring they receive the outreach and treatment they need.

The Soloist movie a good story, but not the whole story

The Soloist, a true story about a gifted classical bass player suffering from schizophrenia and the *Los Angeles Times* columnist who takes an interest in him, is both colourful and moving.

It's a movie well worth seeing.

It doesn't, however, tell the whole story – what lies behind the shocking degradation of the severely mentally ill in Los Angeles and in many other parts of the United States.

The soloist is Nathaniel Ayers (played by Jamie Foxx), a black musician from Cleveland who, in his youth, was good enough to win a place at the famous Juilliard School for the performing arts in New York.

The newspaper columnist is Steve Lopez (Robert Downey Jr.) who accidentally discovers Ayers playing his heart out on an old violin with just two strings, in Los Angeles' Skid Row. Ayers, now in his fifties, is the proverbial street person – sleeping in a doorway, packing all his belongings in a shopping cart, and deeply troubled.

Lopez, the newspaperman, sees the possibility of a good column or two, but is soon deeply engaged in trying to help Ayers. The story develops from there, with triumphs and setbacks, the chance encounter turning into an unlikely friendship. In the end, we see Ayers, a sister from out of town, and Lopez attending a concert of the Los Angeles Philharmonic.

This summary falls far short of doing justice to the humanity of the movie and its brilliant acting and cinematography. What's clearly missing in the movie, however, is any exploration of why Ayers ended up on the street, why he isn't being helped with medication, and what lies behind the appalling misery, degradation, and tragedy of the city's Skid Row.

The movie at least does graphically show just how bad it is, with its portrayal of the area and its mentally ill and addicts – most of whom are likely mentally ill as well – that is sheer bedlam.

The portrayal is chilling. One can't help asking, as one watches, how this squalor and cruelty are possible in a major city in what is still the richest country in the world – a country, moreover, that has pretences of being civilized. No explanation is given, or even a hint of one, except for a brief interchange between the columnist and a mental-health worker. The newspaperman raises the question of why Ayers hasn't been committed so he would have to take medication.

The worker shrugs the question off with a skeptical remark about there being too many diagnoses and too much talk about medication, and besides there's the law.

That's it, on the key factor behind the plight of the severely mentally ill in the city. Of course, it's not an over-reliance on medication but the very opposite – the obstacles to committal where medically appropriate and the consequent lack of treatment – that lie behind the horrible, surrealistic, gut-wrenching Skid Row scene that is the backdrop to the movie.

In the book with the same title by Lopez, on which the movie is based, he does a slightly better job with the issue.

He interviews a local activist with the National Alliance on Mental Illness (NAMI) who has a son with schizophrenia roughly the same age as Ayers.

How can people be left to sleep on filthy and dangerous streets in what is an outdoor dumping ground, she asks Lopez.

In no small part due to her own efforts and awareness, her son lives in a group home, meets regularly with a psychiatrist, and takes medication to control his condition. He's doing better than she had thought he could.

Lopez also attends a NAMI week-end conference in Irvine, California, where he talks to the California spokesperson of the Treatment Advocacy Centre, an organization urging a more pro-active approach.

She tells the story of her husband's sister who, although quite ill, couldn't be committed because of restrictive provisions in California. The sister ended up murdering her mother in a psychotic rage.

The volunteer advocate, speaking of the situation in Los Angeles and elsewhere in California, is straight-forward. Isn't it more humane, she asks, to intercede in the interest of the person's own welfare rather than to let them disintegrate on the street because of their illness, for which they don't have insight?

Lopez allows she may be right, but lacking sufficient experience, he still sits on the fence. It's too bad that he didn't have a chance to read E. Fuller Torrey's book, *The Insanity Offense*, which carefully documents the horrors of not providing treatment, but which came out after *The Soloist* was written.

The scenes of bedlam shown in the movie version, however, are condemnation enough of California's cruel obstacles to treatment.

(For a review of *The Insanity Offense*, see the NSSS Advocacy Bulletin's April issue. Please go to our website's Newsletter page for the link.)

FEEDBACK WELCOME

We welcome your comments on anything you read in the Advocacy Bulletin. If you have a story of your own about struggles with the system or short-comings that need to be remedied, and would like to tell us about it, please also get in touch. You can drop by the Family Support Centre, call us at 604-926-0856, or send us an email at advocacy@northshoreschizophrenia.org.