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Overhaul of mental-health management called for

The North Shore Schizophrenia Society has asked Vancouver Coastal Health (VCH) for a fundamental overhaul of senior mental health management in Vancouver, following a review of events leading to the suicide of Vancouver resident Marek Kwapiszewski.

VCH has agreed to look into the case, but it's not clear whether they're prepared to tackle the root cause behind such preventable tragedies – Vancouver mental health's fundamentally flawed approach.

Kwapiszewski, who was seriously mentally ill, jumped off the Granville Street bridge to his death June 29, 2008 after repeated efforts by his sister Halina Haboosheh to get help for him were unsuccessful.

Haboosheh lives in North Vancouver.

In the 20-month period from December 2006 through to her brother's death, she and others working with her contacted Vancouver mental health services 16 different times, desperately trying to get them to intervene as her brother showed more and more troubling behavioural symptoms, but she was unable to get him into hospital and treatment.

The request for the management overhaul and for a "major cultural change" was submitted late June to Dr. David Ostrow, acting CEO of Vancouver Coastal Health Authority. It called for an independent inquiry, under Ostrow's aegis, into the VCH failure, expressing little confidence in mental health management addressing the failure, given their own responsibility for it.

At the heart of the Kwapiszewski tragedy was a disregard or ignorance of the Mental Health Act, with service providers in effect insisting he needed to be dangerous before he could be committed. The Act, however, allows for involuntary committal to "prevent the person's or patient's substantial mental or physical deterioration." Dangerousness isn't required.

At one point, a psychiatrist at the Midtown Mental Health Team, on examining Kwapiszewski, found his insight was limited, his judgement impaired, his speech was pressured, he might suffer from bipolar disorder, he had a previous psychotic break (the diagnosis was schizophrenia), and he would benefit from treatment. He also refused to take medication (because he was convinced it was tampered with and he would be poisoned).

On the face of it, he not only needed care and treatment to protect him from deteriorating – which qualified him for certification – but substantial deterioration had already occurred.

The psychiatrist nevertheless stated in her report that he was not committable – really a judgement that he was not dangerous enough.

In the end, of course, the mental health team and Vancouver Mental Health Emergency Services, to whom Haboosheh also appealed for help, didn't protect Kwapiszewski from danger, either.

The problem is systemic, not unique to this case

If it were an instance of one practitioner misunderstanding or misapplying the committal criteria, NSSS would in all likelihood have quietly brought the case to the attention of the manager of mental health services, for review and corrective action.

The use of the incorrect requirement for committal (dangerousness) rather than the actual leading criterion (to prevent substantial deterioration) is systemic, however – deeply ingrained in Vancouver mental health service's approach.

It is such a deep-rooted fault and so very basic, in NSSS's view, that nothing short of a major cultural change, and what's required for such a change, is going to remedy the situation.

Hence the request, in the submission to Ostrow, for a "fundamental overhaul of senior [mental health services] management" in Vancouver.

To illustrate how deep-rooted and general the problem is, the NSSS submission cited two cases involving senior people in the system getting the committal provision wrong or misapplying it, one involving the head of the Psychiatric Assessment Unit and the other a senior community mental health trainer.

In a properly managed mental health system, that would have never happened. They, like the various service providers involved in the Marek Kwapiszewski case, would not have made the basic mistake they did.

The problem, too, is of long-standing – something senior management of mental health services should have dealt with pro-actively long ago.

VCH's response may not address the real problem

In response to the NSSS submission, VCH CEO Ostrow has arranged for a review of the Kwapiszewsk case by a psychiatrist external to VCH.

Independence of the reviewer from the health authority was one of the stipulations in NSSS's request for an inquiry.

The appointment of the psychiatrist is imminent.

The way the review has been framed by VCH, however, leaves questions about whether it will get to the heart of the matter and lead to the necessary changes.

The review will focus on the assessments and decisions in the particular case, as different from the collective VCH failure which lies behind it, although comments on broader issues may ultimately be invited.

It risks, in other words, being superficial and missing the real problem.

The NSSS Advocacy Bulletin will be reporting on the review as it proceeds.

The nine-page, 4,500-word NSSS submission may be viewed at www.northshoreschizophrenia.org/marek.pdf.

B.C. not only place information sharing runs into roadblocks

B.C. isn't the only place where the sharing of clinical information with family members runs into roadblocks. The U.K. is an example.

Here's a case history where we've been involved, since the patient at one point was in Vancouver.

The young man, quite ill, is now in hospital in England. His parents are desperate for information about how he's doing, but the psychiatrist and field worker in the case refuse absolutely to tell them anything because the patient hasn't given them permission.

He hasn't given them that permission because he has florid paranoid delusions about his parents, but that is ignored. The embargo on the parents is maintained.

This means that the parents won't be able to give their feedback to the hospital's observations, for diagnostic and treatment purposes. It effectively excludes the family altogether from the treatment team, contrary to best practices. Applicable U.K. legislation, however, doesn't take those factors into account.

A little background on the case illustrates just how bizarre the U.K. legal impediments are.

What possible reason could there be, in the practical circumstances, for shutting out the parents? The parents already know their son is ill. They were the ones who watched with perplexity and anguish as his illness took hold just as, later, they were the ones who kept an eye on him and supported him. There was also a previous hospitalization.

The parents, moreover, have in hand all of the graphic details of his recent relapse into psychosis, details which they themselves provided to mental health services and which contributed to his recommittal, or "sectioning" to use the British term.

In this case, too, because the paranoia was directed at others as well as the parents, hundreds of other people in the U.K., not to mention the police, are aware of his illness.

The notion that not letting the two people closest to him know how he's progressing in hospital, and that somehow this protects his self-respect and prospects, or protects him from stigma or embarrassment, becomes absurd.

The only thing it does is to detract from his treatment clinically, by excluding family involvement.

Applicable legislation in the U.S., most importantly HIPAA, or the Health Insurance Portability and Accountability Act, isn't much better.

It doesn't prevent family members passing on information to psychiatrists and other service providers. If, however, there is no consent from the patient, any information going the other way is barred, regardless of how delusional the patient may be.

B.C. provisions much better, but many professionals ignore them instead

Unlike the legal obstacles in the U.K. and the U.S., the relevant legislation in B.C. – the Freedom of Information and Protection of Privacy Act (FIPPA) – does allow for the sharing of information with family members if it makes practical sense, even without the consent of the patient.

See www.northshoreschizophrenia.org/sharing.htm for details.

Many, perhaps most, professionals, however, either are ignorant of their own legislation, don't understand it, or refuse to follow through.

Let's return to the case of the patient from England, noted above. For a brief period he was in St. Paul's Hospital in Vancouver.

An NSSS support worker, deeply involved on behalf of the parents, was told authoritatively by the hospital's social worker that she could not share information with him because the hospital's privacy policy didn't allow it.

On further investigation, it turned out that the hospital's written policy, once one worked through all the boilerplate, did allow for it – no surprise because it had to conform in law to FIPPA. In practice, though, that didn't make any difference.

This is just one of many such instances documented by NSSS.

For families in B.C, the frustration of having to deal with the lack of professionalism on this issue is even worse, in its way, than having to work with bad law to begin with.

And, most important: Clinically, for the patient, it detracts from achieving the best possible outcome.

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.

Ross Allan inquest brings forward 43 recommendations

"For the first time in six years, we felt that we had been fully listened to," Kim and Lynn Allan of Mission wrote to friends and supporters, after a coroner's jury in June, deliberating on their son Ross's death, delivered a record 43 recommendations.

Ross, who suffered from paranoid schizophrenia, hung himself in a staff washroom at MSA Hospital in Abbotsford after managing to escape observation, although his parents had called every shift at the hospital to alert them he was suicidal.

Leading recommendations by the jury had to do with the need for physicians to properly understand the committal provisions of the BC Mental Health Act and to obtain and pay heed to collateral information from family members.

Another recommendation called for psychiatrists to share information with family members and include them in the treatment plan.

These are some of the same issues that preoccupy NSSS in its advocacy work and that are often discussed in these pages.

Other jury recommendations dealt with the circumstances by which Ross was able to take his own life – in a hospital setting where he should have been safe and secure.

The family had full participant status at the inquest and courageously took advantage of it to ask questions of witnesses and bring out the whole story.

"It was a very intense and emotional 10 days," they commented afterwards.

The Allans had been struggling with cracks and flaws in the medical system for years.

For the complete verdict, go to www.pssg.gov.bc.ca/coroners and enter "Ross Allan" in the Search box.