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"Independent" reviews not necessarily independent

The independent review of the Marek Kwapiszewski case, promised by Vancouver Coastal Health CEO David Ostrow, may not be so independent after all.

VCH's approach also throws into question whether internal VCH reviews, whatever their stated intentions, can ever get at the root of problems, especially where those problems are systemic and where senior management may be responsible.

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.

The North Shore Schizophrenia Society, in a lengthy and carefully documented submission on the case, asked Ostrow to launch an inquiry and that the person leading the inquiry should not be part of VCH. (See "Overhaul of mental-health management called for" in our September 2009 issue.)

Ostrow, in agreeing to a review, pledged to appoint a psychiatrist independent of VCH, and subsequently Dr. Roy O'Shaughnessy, a specialist in forensic psychiatry who doesn't work for VCH, was retained.

Enter risk management and a conflict of interest

So far, so good. Then, however, VCH involved its director of risk management, Darren Kopetsky, in the planning of the review. One of his principal functions is to protect VCH from liability. In that capacity, he has a clear conflict of interest in working on the review and undermines any claims to independence the review might have.

Both Kopetsky and Dr. Patrick O'Connor, Vice-President, Medicine, Quality & Safety, who is overseeing the review, have skirted the problem, pointing to other roles that Kopetsky has, one of which is director of client relations.

These other roles, however, don't negate the conflict of interest that a director of risk management and employee of VCH incurs when he participates in a review that is supposed to be independent of the health authority.

NSSS, in an email submission to Ostrow October 30, pointing out the conflict of interest, has asked that Kopetsky be removed from the review.

"This isn't a commentary on Mr. Kopetsky personally," the submission noted, "but a requirement to protect the integrity of the review and of Dr. O'Shaughnessy's role in it."

As of *Bulletin* deadline 10 days later, no response has been received.

Framing of the review undermines its purpose

In the meantime, it has become clear that the review is being framed in such a way that it will miss the point.

As documented by NSSS, service providers knew Kwapiszewski was quite ill, but in effect insisted he needed to be dangerous before he could be committed. The B.C. Mental Health Act, however, allows for involuntary committal to "prevent the person's or patient's substantial mental or physical deterioration."

Kwapiszewsk certainly qualified to be taken into care and given protection.

This ignorance or misinterpretation of the Act by service providers is deeply rooted in Vancouver community mental-health service's culture.

Instead of looking at this, however, the review, from what NSSS has been told, will focus instead on what signals of suicidal intention by Kwapiszewski were missed by the mental health team and Mental Health Emergency Services. In other words, it will try to find out why they missed predicting he would commit suicide.

That, ultimately, is a hopeless task. Approximately half of all those suffering from schizophrenia attempt suicide at least once in their lifetimes, most without any prior warning. If one could pick up the signals of immediate suicidal intention with any reliability in those cases, all suicides in the category would be prevented.

Suicidal intention, however, isn't the point anyway. Mr. Kwapiszewski should have been committed because he was deteriorating, for his illness. For that matter, the best way to prevent suicides is to ensure that people who are ill are hospitalized and treated for their psychosis.

By focusing on suicidal intention, in other words "dangerousness," the review will be making the same fundamental mistake that led to Mr. Kwapiszewski's suicide to begin with.

It's another demonstration of how deeply rooted the flawed VCH mental-health services culture is and why a major change in senior management and training needs to be undertaken.

The *Bulletin* will be maintaining a watching brief on the review as it goes forward.

Respecting dignity means assuring needed treatment

"Respecting dignity" and its sister expression, "respecting privacy," are surprisingly often cited by mental health workers as an explanation for not pursuing an assessment, not insisting on entering premises, or not gathering information that might be important.

To intervene in the circumstances, it's suggested, is to be heavy-handed and to offend against the rights of the mentally ill.

Meanwhile, family members, often desperately worried about their loved one who is ill, and urging action, are made to feel crude and insensitive, with no regard for the dignity of others or, even worse, casually discriminating against the mentally ill.

Surely, though, the opposite is the case: that the best way of "respecting

the dignity" of the mentally ill is by ensuring they receive the outreach and treatment they need and, for that purpose, taking any and all protective steps that are necessary.

And the corollary: that failing to do so is to make a mockery of respecting dignity and also to offend the mentally ill in a profound way.

Here's a case history. A mother in the B.C. interior is concerned about her son in Vancouver who suffers from. schizoaffective disorder. The son has been relatively high functioning, and worked as a qualified electrician for a while, but is known to have requested solitary work. Not wanting to acknowledge his illness, he is probably not taking his medication. He has moved to another apartment but refuses to disclose the address. Most of the time he does not answer his cell phone.

Then he calls his mother. The conversation shows her shows just how ill he is.

Extremely worried, and mulling over her options, the mother has an idea. She calls Car 87 – Mental Health Emergency Services (MHES) in Vancouver. She explains the situation and asks if they would please phone the various mental health teams in Vancouver to see if he is seeing anyone.

She is told that that information is all on the computer and, no, her son has not seen anyone at a mental health centre for several years.

The mother then asks, "If you can do that, can you tap into the car registration database to get an address?"

"Yes, we could," is the reply, "but we won't as that would be a breach of his privacy."

The mother replies in turn, "I sure hope he has a guardian angel looking after him because he is in trouble." No further help, however, is offered.

A week later it is discovered that at the very moment of her call to MHES, her son was hanging from his neck in his apartment, having committed suicide.

Knowing that if MHES had acted on her suggestion when she called, her son wouldn't have been saved, isn't much solace to the mother. She not only is left grieving for him, she also is stuck with the bitter memory that MHES would not have helped him even if they did have time.

The added irony is that drivers' address information is routinely asked for and supplied by ICBC in far less serious circumstances, for parking lots and municipalities to collect parking fines, for example.

True respect for the dignity of the mentally ill is being sensitive to them in their struggle with their illness and providing the outreach and treatment they need. Failing to intervene when circumstances call for it shows no respect at all.

Coming in the next issue of the NSSS Advocacy Bulletin

Accountability of mental-health professionals for failures in judgement or not following best practices is difficult to come by when the practice of health authorities is not to admit any liability if they can help it, which works out in practice to not acknowledging anything at all.

Cold weather law won't protect from ravages of illness

Legislation recently introduced in the B.C. legislature that will allow police to escort mentally ill street people to emergency shelters in extremely cold weather may protect them from winter cold but won't protect them from the ravages of their illness.

The new legislation, moreover, as many critics have pointed out, wouldn't be necessary if police pro-actively used their powers under the B.C. Mental Health Act to take people to hospital when their illness so confounds their judgement that they put themselves at risk.

Section 28 gives police officers that power when they find someone "likely to endanger" themselves. Once the person is taken in charge at the hospital by medical staff, a psychiatric assessment follows, addressing the illness itself as should be the case.

There, however, is the rub. For help under Section 28 to be effective, hospital psychiatrists need to pro-actively use the Mental Health Act in turn, committing someone who is seriously deteriorating or in need of protection. This, too, is provided for in the Act, in Section 22.

As likely as not, however, hospital staff will wrongly require dangerousness for committal, and discharge the person instead, or keep them only for a brief period. Vancouver police, frustrated at seeing many ill people back on the street almost immediately, without their having been properly stabilized, have been discouraged from using Section 28 as actively as they should.

"What's the use?" they tell themselves.

This would have been a contributing factor in the case of the "woman known as Tracey," who burned to death in a cold spell last winter trying to warm herself by lighting a candle. The case precipitated the introduction of the new shelter legislation.

Police officers who had earlier talked to Tracey and tried to persuade her to seek shelter could have taken her to hospital under Section 28. She was ill and she was putting herself at risk. The apprehension of Tracey for her protection and care, using that section, did not however happen.

The government, with the proposed new legislation, is either ignoring the real lesson of the tragedy or is not prepared to underwrite mental health services and housing sufficiently so that others like Tracey will be helped to get back on their feet again.

A more detailed account of the circumstances leading to the death of the woman called Tracey was carried in the *Bulletin's* February 2009 issue, accessible on the NSSS website at www.northshoreschizophrenia.org.

Meanwhile, psychiatric acute care wards are already under great pressure, and in Victoria, to cite one example, the number of beds has just been cut back by the health authority, because of budget constraints, making an already difficult situation worse.

It appears that the real lesson from the death of the woman called Tracey has not been learned at all.

FEEDBACK WELCOME

We welcome your comments on anything you read in the Advocacy Bulletin. If you have a story of your own you would like to tell us about or an issue you wish to bring to our attention, please also get in touch. You can either call us at 604-926-0856, drop by the Family Support Centre, or send us an email, at advocacy@northshoreschizophrenia.org.