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Could this death have been prevented?

The death of Ben Williams of North Vancouver from a heart attack raises questions, not about treatment for heart disease but about the culture of mental health services on the North Shore.

While heart failure was the immediate cause of death, the underlying cause was his mental illness, which prevented him from understanding the need for treatment.

And instead of committing him to hospital where he might have been helped, psychiatric acute care and Community Psychiatric Services (CPS) maintained they were unable to act, despite the pleading of his family and girlfriend.

"He's going to die," his mother agonized at the time. Tragically, she was right.

Ben, in his early fifties, suffered from schizophrenia. He was affable and much liked by those close to him. Last year he was diagnosed with a heart condition and prescribed medication for it. He took it for a while and then stopped

He developed classic symptoms of heart disease, like shortness of breath and swollen and puffy features, not helped by a huge belly (the result of olanzapine; he had since been switched to risperdal). A case worker noticed his fingertips were blue. In his last weeks he had difficulty getting out of bed.

He adamantly refused, however, to go to hospital; grew red in the face and angry if pressed about it. He claimed he had no need for it, and offered unrealistic explanations for his obesity and shortness of breath. He didn't like people telling him what to do and had a deep antipathy to hospitals.

As well as ignoring his heart medication, he had cut his risperdal dose in half because he thought the medication affected his sleep, although he felt better with the regular dosage.

After a single visit to see about diets, he also had refused to go back to a CPS health and wellness clinic, claiming he could look after dieting himself, which however he was unable to do.

And he continued to suffer from what his girlfriend described as "terrible hallucinations," menacing and distressful.

In summary, he was mentally ill; wasn't able to manage his health properly; avoided group help (hospital, wellness clinic); didn't understand how sick he really was (among other signs, he had told his mother not to worry, things would work out), and had put himself in danger.

Finally, in response to repeated concerns of his mother and girlfriend and of a sympathetic case worker, a psychiatrist and nurse from CPS went out to see him. Ben presented well and his apartment was tidy. The psychiatrist decided he didn't qualify for certification.

In a subsequent telephone conversation, the nurse told the family to pull back – that Ben needed to be left alone.

Not long after, his two sisters, seeing the difficulty he was in, went to the psychiatric ward at Lions Gate Hospital. A nurse there said that because of Ben's refusal to go to hospital, their hands were tied.

At roughly the same time, his girlfriend, alarmed at some swelling she noticed, called 911. He had also been showing signs of developing incontinence. The police and an ambulance arrived, but claimed they didn't have the power to take him to hospital involuntarily and he wouldn't come on his own.

Three days later, on December 22, Ben left his apartment for a short walk to his bank. He collapsed on the street and died in Emergency.

"Physical deterioration" is covered by committal law

Could Ben Williams, in fact, have been committed?

The committal provision in the B.C. Mental Health Act does allow for committal in case of physical deterioration of a person with a mental disorder – indeed allows for it on two separate counts.

The leading, and self-standing, criterion for committal is "to prevent the person's....substantial mental or physical deterioration." This reference to physical deterioration is specific and clear.

The second criterion for committal is to "[protect] the person or patient." This protection criterion is broadly phrased to allow, among other things, for the handling of unique circumstances where the mentally ill person is at risk not from violence, like suicide, but from other kinds of significant harm.

Committal under the Mental Health Act allows only for psychiatric treatment. Should the patient, once in hospital, still refuse treatment for the physical risk, then special provisions in the Health Care (Consent) Act come into play, under which the patient's capability in understanding the need for treatment is decided on. Mental health services, unfortunately, did not get Ben that far.

An additional explanation raises another question

A second explanation for the way the Ben Williams case was handled is of equal concern.

The family was told, after his death, the problem was there was no place in the hospital to put people like Ben.

It's not quite clear what was meant by this remark. It's not beyond the realm of imagination, however, for hospital staff, once the first committal certificate was signed, to have taken Ben from Emergency to the cardiology ward and provided him with a single room and security if necessary. For the psychiatric side, a psychiatrist could have seen him there.

The mentally ill and their families count on the system to show initiative in unusual circumstances and to act with some urgency, based on clinical need.

This doesn't appear to have happened in the Ben Williams case.

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 call us at 604-926-0856, drop by the Family Support Centre in Ambleside Village, or send us an email at advocacy@northshoreschizophrenia.org

Families' knowledge and vital experience downplayed, ignored

The advice to Ben Williams' family that they pull back is not without its ironies.

It suggests they were crowding Ben with their concerns and only making matters worse; that they weren't treating him as an adult (after all, he was in his fifties); that unlike the psychiatrist and nurse, they lacked the necessary experience to judge or were too involved emotionally to handle things properly... in a phrase, that they should "let go."

Most families with mentally ill relatives would in fact like nothing more than to pull back and let their loved ones get on with it, but only if they can be assured their ill relatives can adequately manage and that the necessary help of service providers is available. That assurance, however, isn't always there.

To pull back in such circumstances is to abandon their loved one to their illness, an illness, moreover, which often robs people of necessary insight into their own condition.

Far from family members being asked to pull back, they should be carefully listened to and their concerns heeded and acted on.

The Michael Wild case: the pattern repeats itself

The pattern of not giving adequate weight to family members' concerns unfortunately repeated itself in the Michael Wild case.

Michael, who suffered from schizophrenia, had done well for years but had begun to seriously deteriorate. Either he had stopped taking his medication or the dosage was so low it wasn't holding the psychosis in check.

The parents informed CPS of Michael's difficulties as his strange behaviour and delusions became more explicit. They wondered if they should ask the police to intervene, but were told not to do so, that CPS would look after it.

On December 31, Michael did voluntarily appear for a meeting with a CPS team. He was openly delusional. The meeting did not go well, and he stomped out in anger.

The signal from the parents, that he was so very ill – a signal indicating the need for committal – was apparently missed. Instead the CPS team let him know by phone they had doubled his dosage.

At 3 a.m. the next day, January 1, a man was observed exiting his car and climbing over the railing on the Lions Gate Bridge. The car, which police found abandoned on the bridge, was Michael's. The body has not been recovered.

Leaving it to professionals not a reliable treatment plan

The horrific case of Ashley Smith, the young New Brunswick woman who ended her life in an Ontario prison cell as guards watched, provides another illustration of the pattern.

When the angry mother was asked by CBC radio why she hadn't forcefully intervened earlier, she replied that she had tried making her concerns known, but had been told to "leave it to the professionals."

Only when it was too late did she realize how hollow that instruction was.

(For the chilling CBC television documentary on the case, please go to www.cbc.ca/fifth and click on the "Out of Control" documentary link.)

Psychiatrists, psychiatric nurses and case workers are essential to the treatment of the seriously mentally ill, and the knowledge, skills and devotion of many of them are deeply appreciated by family members.

What's all too often missing, though, especially among some older practitioners, is the recognition that family members, in their own way, also bring necessary knowledge and expertise to the table – knowledge and sensibility that are vitally important.

Not to recognize this is clinically negligent and can result in unnecessary tragedy.

St. Paul's MH staff share information

Mental health professionals at St. Paul's Hospital in most cases will share information with family members, even if the patient hasn't given permission.

At least this was the policy spelled out by operations leader Blaine Bray and acting program director Scott Harrison in a meeting with NSSS board members Janet Blue and Herschel Hardin in January.

This was welcome news. The policy only makes common sense, and is good clinical practice.

Usually when a patient refuses permission it's because they're very ill and paranoid. Family members may even be part of their paranoid delusions. It's exactly in such serious cases, however, that the sharing of information with family members, by service providers, is most important.

The Freedom of Information and Protection of Privacy Act (FIPPA), moreover, allows for such sharing in cases of mental illness.

All too often, service providers will refuse to tell family members what is happening when patient permission isn't forthcoming, wrongly citing confidentiality requirements and not taking the context into account. This has also been NSSS's previous experience at St. Paul's.

The explanation by Bray and Harrison goes some distance in clearing the matter up.

They advanced some qualifications to the policy, however, that need to be re-examined.

For example, they said that sharing information requires family members to meet with mental health staff in person rather than over the phone. This seems reasonable on the surface, but what if, let's say, the parents of someone admitted to St. Paul's live out of town, maybe even in another province or country.

And even for those who are local, the policy makes no sense for subsequent contact after the initial one, although for a major discussion, meeting in person may be appropriate for other reasons.

Still, the commitment in general to share information represents a large step forward.