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The more things change, do they remain the same?

In the 1990s, NSSS and other family members involved in advocacy thought progress was being made in mental health services in British Columbia. They felt a great sense of accomplishment in having helped move things forward.

That's been replaced, now, with a widespread feeling that in many ways nothing much has really changed, and in some respects help for the mentally ill has even deteriorated.

The late 1980s and the 1990s saw schizophrenia societies in Canada doing pioneering work in bringing serious mental illness, especially schizophrenia, out of the closet, and in changing treatment approaches for the better.

Nowhere did the horizon look brighter than in British Columbia.

- Early psychosis intervention (EPI), which they had publicized when the idea was virtually unknown in North America, became part of best practices. EPI almost took on the status of a fad in psychiatric circles.

- Family involvement as part of the treatment team was being talked about and even accepted by many professionals, at least in theory. At a schizophrenia conference at Riverview Hospital, family involvement was applauded. It, too, became part of best practices.

- In 1998, the Ministry of Health issued a fact sheet on the Freedom of Information and Protection of Privacy Act (FIPPA), explaining that information could be shared with family members even when the patient, perhaps in the grip of paranoid psychosis, had not given consent

This sharing of information, essential to proper family involvement, was specifically provided for in FIPPA. The ministry's fact sheet added its own clarity and authority on the point.

- Plans for downsizing Riverview had surfaced, plans which NSSS and many others opposed, knowing of Riverview's unique value, but the opponents at least had the assurance of government that equivalent care would be provided "in the community," although they were skeptical of promises for the future and continued to fight for keeping Riverview alive.

- In 1999, a revised Mental Health Act was proclaimed, allowing for involuntary admission to prevent substantial mental or physical deterioration. Dangerousness wasn't required for committal. Providing protection was a second grounds for committal. This cleared the way to get very ill people into hospital for treatment.

In fact the way had already been clear under the old legislation, as confirmed in a landmark court decision, *McCorkell 1993*, where Justice Ian Donald had found that the protection clause for committal in the then-existing Act had a broad scope.

And a Guide to the Mental Health Act was produced spelling everything out so there could be no misunderstanding. Training workshops were organized for the new Act.

With all these major steps forward, there was great hope we were finally saying goodbye not just to discredited Freudianism, but also to professional backwardness. It looked as if, in B.C. at least if not in the rest of Canada, the severely mentally ill would get the help they needed and deserved.

Expected change runs into a blindness to the obvious

Things did not work out as expected. Many psychiatrists and case workers are doing a better job, especially among the younger generation without inherited baggage from the past. In many other ways, though, little has changed, and for the most severely affected, their situation has become bleaker rather than brighter.

Riverview was indeed radically downsized, but the kind of intensive longer-term care needed for the most severely ill was not created. Instead they got community care light, altogether inadequate for them.

In 2008, the Vancouver Police Department issued a blistering report, Lost in Transition, documenting the disaster.

Vancouver Coastal Health is now acknowledging, according to a draft report, that 40 per cent of those most severely ill will require a "high level of support," including long-term residential care, and a further 50 per cent will need "ongoing support" with daily supervision.

The medical director of the Burnaby Centre for Mental Health and Addictions, Michael Krausz, is saying essentially the same thing, arguing for care "across the continuum" rather than intense but relatively brief hospital intervention and then discharge.

The Burnaby centre's patients have concurrent disorders, common with the mentally ill. The average stay at the centre, once expected to be nine months, is now approaching a year, with some having been there considerably longer, demonstrating in practice what the need is.

We're now in a position of having to essentially recreate what was destroyed, if not doing so at Riverview, then in some other form.

Old entrenched attitudes have blocked change, too

The hopes for early psychosis intervention and the new Mental Health Act have not fared much better.

EPI has made some strides, like the EPI program in Fraser South, part of the Fraser Health Region. If, however, the ill person refuses to accept help because of a lack of insight or if the person is heading for a second or third break rather than a first one, EPI doesn't apply. People are back to waiting it out until acute crisis hits, with all the damage and often tragedy that results. The old problem of delayed treatment remains.

Take the recent case of a quite psychotic young man in Vancouver who had previously been diagnosed with schizophrenia and been hospitalized,

and who had also come to the attention of the police. Mental Health Emergency Services, who had contact with him, would not commit him because, as they put it, "he isn't quite ready yet."

He was, though, already profoundly ill.

Early intervention, and the prevention of at least some of the damage that occurred to his brain and future outcome from the delay, did not exist for him. And given his concurrent depression at the time and the high risk of suicide in those with schizophrenia, it's only by the grace of chance that he didn't end up dead as well. Only when NSSS began pushing was he finally taken into treatment.

Imagine someone showing obvious symptoms of cancer or diabetes? Would the system delay responding because "he isn't quite ready yet"?

A good deal of the crisis support work done by NSSS is trying to get obviously ill people into hospital when involuntary admission is required and when they should have been hospitalized long before.

Either dangerousness is the *de facto* criterion in the system for involuntary admission or, astonishing as it may seem, service providers don't know what their own Mental Health Act actually says on this most central matter.

It's as if the current Mental Health Act didn't exist, not that the previous one was properly interpreted, either.

Information sharing also runs into brick walls

At least some practitioners now understand the importance and practical common sense of sharing information with close family members, even when consent of the patient isn't forthcoming. (See, for example, the item on St. Paul's Hospital policy in the March 2010 issue of the *Bulletin*.)

NSSS, however, continues to run into case after case of practitioners who cite confidentiality limitations instead, often referring with stern authority to their health authority's policy when in fact the policy, conforming necessarily to FIPPA, says no such thing.

These aren't junior or inexperienced people, either. They can be top psychiatrists, veteran case workers, medical directors, or senior mental health service managers. Even privacy officers may not have a complete grip of their file when it comes to the mentally ill.

The *Bulletin* has regularly carried reports on this disturbing professional syndrome, and reported as well on the widespread disregard of the wording and intent of Section 22 (the committal provision) in the Mental Health Act and the tragedies and other harm that occur as a result.

The bright promise of the 1990s is taking a lot longer to prove out than expected. We need new strategies to help us get there.

Family peer workers needed in training of psychiatrists

It has long been a puzzle. How can so many professionals not know the basics of what for the mentally ill, and for family members, are crucial matters?

Why should an organization like NSSS need to bring the Ministry of Health's fact sheet on FIPPA to the attention of a medical director or correct an intake worker's incorrect citation of the provision for involuntary admission, and often have to force the issue, especially when both matters are dealt with clearly in the Guide to the Mental Health Act?

Aren't these things mental health professionals, of all people, should know about?

The problem may lie in part in how psychiatrists are trained, that is, largely by other psychiatrists. This makes sense for many things, like symptomology, the neurology of mental illness and medications, but where some crucial matters are ignored or underplayed in the prevailing psychiatric culture, it means the syndrome is replicated.

The same applies to the training of psychiatric nurses and social workers in the field.

One obvious remedial step is to systematically include experienced family members in both training and refresher sessions, as integral parts of service providers' formal instruction.

We welcome your comments on this matter, especially if you're a psychiatrist or other service provider yourself.

Request for inquest in Ben Williams case

The chief coroner of B.C. has been asked by NSSS to conduct an inquest into the death of Ben Williams of North Vancouver on December 22 last year.

Mr. Williams collapsed on the street from heart failure and died shortly after in Lions Gate Hospital emergency. The underlying cause, however, was his mental illness, which prevented him from understanding the need for treatment.

Community Psychiatric Services declined to commit him so his physical illness could be dealt with in hospital, maintaining they were unable to act, presumably because he wasn't floridly psychotic. The Mental Health Act, however, allows for involuntary admission to "prevent substantial ....physical deterioration."

The request questions why, in the circumstances, Mr. Williams was left to his own devices when the danger he was in was apparent, while he himself was unable to recognize the danger.

His physical symptoms were quite severe, from shortness of breath and swollen and puffy features to incidents of incontinence and difficulty getting out of bed.

The NSSS letter to the chief coroner underscores the importance of thinking through the connection between mental illness and untreated physical illness, especially given the relative vulnerability of the mentally ill to heart disease, stroke and type 2 diabetes.

You can read the request for an inquest on the NSSS website, at www.northshoreschizophrenia.org, either by clicking on the link in the News and Events item on the story or going directly to the Media Centre page.

FEEDBACK INFO

Please feel free to send us 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, please also get in touch. You can call us at 604-926-0856, drop by the Family Support Centre, or email us at advocacy@northshoreschizophrenia.org.