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Those who need help most can be short-changed

In all of the controversies about mental health services and all of the new psychiatric developments good and bad, the heart and soul of help for the severely ill sometimes doesn't get much thought.

In the process, those who need help most can be short-changed.

We're referring to acute care and, by extension, to long-term intensive care for the most seriously ill.

Without a foundation of strong and adequately underwritten acute care, mental health services become skewed and, for many who need treatment but may have it delayed, quite damaging – sometimes, through suicide, fatal.

Lions Gate Hospital acute care has recently been functioning at full capacity, which is a way of saying there's not always a bed for someone who needs one.

It's not the first time. Occasionally in the past as well, people who were psychotic or decompensating were sent home until a bed became available. This can't help but increase pressure in turn to discharge patients earlier than clinically preferable, in order to make room for others.

This isn't a reflection on the people working at A2 (the Lions Gate acute care ward), but on how resources are allocated in the larger mental-health system.

Psychiatric acute care beds had previously been cut at Lions Gate Hospital from the level they had been in the past.

Meanwhile, at the Eric Martin Pavilion in Victoria, where acute care had long been running over capacity, with two improvised beds added to one ward, a whole block of ten beds was closed down by the health authority late last year.

The rationale was to move some beds and resources up island, which in itself might make sense. There was, however, a net loss in beds overall, which only begged the question of why acute care should be cut at all rather than expanded when the need for adequate treatment is so great, especially with the downsizing of Riverview which puts pressure on every other part of the system.

This pressure can work in insidious ways. The Vancouver Police Department, in its damning 2008 report *Lost in Transition*, documents how this has happened in the City of Vancouver. The subtitle of the report says it all: "How a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources."

The report decries "the absence of an acceptable response from hospitals to admit mentally ill patients."

Lack of capacity undermines proactive wording of Act

Instead of acute care taking advantage of the proactive wording of the Mental Health Act for involuntary admission ("to prevent substantial mental or physical deterioration"), in order to help the severely ill, "dangerousness" has all too often, wrongly, become the *de facto* criterion for committal.

Partly it's because many service providers don't even know what their own law says, but it's also because inadequate capacity insidiously dictates how service providers think of involuntary admission and what's required.

"Well, if we used that [the actual provision in Section 22]," a nurse at Community Psychiatric Services intake once said, "we'd have to commit half the people on the Downtown Eastside."

It's become a syndrome, let's call it "inadequate capacity disorder," with all its side-effects, including misinterpretation of the committal provision.

The syndrome has become so entrenched that Mental Health Emergency Services in Vancouver, exactly the agency that should be proactively using Section 22, has as part of its mission to avoid taking people to acute care.

"The goal of MHES," reads a 2009 mission statement, "continues to be the provision of a rapid response to urgent and emergent mental health situations while minimizing admissions to hospital emergency departments. Staff uses the least intrusive resolution to the situation while maintaining the safety of the person with a mental illness and the public."

Avoid hospital emergency (the gateway to acute care), don't even think of Section 22 and hence acute care unless you absolutely can't ignore it ("the least intrusive resolution"), and use dangerousness as the criterion for committal ("maintaining the safety").... It's all there.

There is good reason not to be unnecessarily intrusive, but the effect in practice of this mission statement is that available tools are not being used even though they may be necessary and badly needed.

Shortcomings in treatment, and tragedy, are the result

The result is not only that the severely ill are badly served, but also that suicides and other tragic incidents occur that could be avoided, as the VPD report indicates. Not even maintaining safety is achieved, nor can it be achieved that way where treating the illness is not the first priority.

NSSS has its own experience with this problematic culture. At the heart of the Marek Kwapiszewski suicide case, now being reviewed by Vancouver Coastal at our behest, is the failure of MHES to use Section 22 although its use was clearly called for.

"Inadequate capacity disorder" rules.

Acute care doesn't have the glamour of many other services, or of feel-good programs for the worried well, nor do the people who need it most have fashionability on their side or even much of a voice of their own.

It's nevertheless the cornerstone of any mental health service that prides itself on providing the mentally ill with the help they deserve.

"Mental health kills the mentally ill," says American critic

You may want to read that headline again, just to make sure it isn't a misprint or a mistake.

It isn't.

It's the title of a provocative article by D.J. Jaffe which appeared in the *Huffington Post* in the U.S. earlier this year.

Jaffe is one of the pioneer advocates for the mentally ill in the U.S. and a co-founder of the Treatment Advocacy Center (TAC) in Arlington, Virginia which, among other things, has been fighting for better treatment provision for the seriously ill.

His thesis is that, under the umbrella of "mental health," large amounts of money are being allocated to programs for the "worried well" and the highly functioning, while resources and adequate committal provisions for the seriously ill are short-changed, with often disastrous consequences for those who need help most.

Hence the phrase: "Mental health" kills the "mentally ill."

He tells the story of a middle-aged woman in Scarsdale, New York, where he grew up, who lived in a big house on a large lot, but whose husband had departed and whose kids were at college, leaving her feeling blue. Free hotline services, support groups and counselling were all readily available.

At the same time, a 25-year-old man with schizophrenia started becoming paranoid, but no help was available for him, and he ended up stabbing to death a small boy, nine years old.

The woman's mental "health" needs trumped the young man's mental "illness," Jaffe writes.

The incidents were just parts of a larger canvas where public resources have over time been shifted from the seriously ill to other programs.

According to a TAC study, in 1955 there were 340 public psychiatric beds available per 100,000 U.S. citizens, but by 2005 the number had plummeted to a mere 17 beds per 100,000 persons.

Even taking into account offsetting factors like the better medications now available, community treatment orders, and housing and care that don't require hospital beds, that's an astonishing shift, and it shows in the desperate plight of so many mentally ill in the U.S.

The largest psychiatric hospital in New York, Jaffe writes, is Riker's Island Prison. In California, it's the LA County Jail.

Those who saw the movie *The Soloist* will remember the vivid images of the mentally ill in the streets of Los Angeles living in appalling conditions, with their illnesses running rampant.

Meanwhile, the amount of money spent on mental "health" as different from treatment of mental illness – "making the worried-well less worried," in Jaffe's words – has exploded.

The complete article is available at www.huffingtonpost.com (search by the title in our headline).

For a moving, and deeply troubling, account of the situation of the seriously ill in the U.S., see our review of E. Fuller Torrey's book *The Insanity Offense* in our April 2009 issue (go to www.northshoreschizophrenia.org/bulletin.htm and click on the link) or, better still, consider reading the book itself.

For a review of *The Soloist*, see our May 2009 issue.

Not in Canada? Not necessarily so

Does Jaffe's critique of what has happened in the U.S. also apply to Canada?

The quick answer is that it doesn't. After all, in many provinces, and especially in B.C. – although not in Ontario – we have proactive committal legislation. In the U.S., on the other hand, the provisions for involuntary admission have been overly restrictive, creating obstacles to treatment for those who have no insight into their illness.

Only recently have states begun to adopt a need-for-treatment standard, rather than an imminent danger one, for involuntary admission.

In B.C., we don't have any legislative or structural elements that impede helping the severely ill.

When we mention this to our American friends, however – people who know B.C. – they point to the Downtown Eastside. Is it any better than Los Angeles, they ask. Canadian jails and prisons are full of mentally ill people, too, who should never have ended up there.

New statistics on women starting federal prison sentences in Canada underscore the point. Their numbers have increased 55 per cent in the last decade. Most troubling is that they share many common traits, among them addictions or mental illnesses such as schizophrenia, depression and anxiety disorders.

A full 30 per cent of women incarcerated in that period had previously been admitted to a psychiatric hospital. This is aside from those who had been diagnosed but not hospitalized or who were ill but never got as far as a diagnosis.

"If the mental-health system....is failing, then some of the behaviour linked to symptoms of mental health are now being criminalized," says Ivan Zinger, executive director of the office that serves as the ombudsman for federal offenders.

Good mental health legislation, then, and conscientious mental health workers, aren't enough. In the end, they're going to be held back by resources – the lack of capacity, whether for acute care or intensive longer-term programs.

This bring us back to the question of how resources are allocated – within our economy as a whole, within health authorities and social services over all, and within the aggregate budgets of mental health services.

Here, again, the seriously mentally ill are at a disadvantage. They're not often able to advocate for themselves. High-functioning people with a diagnosis, who are able to get involved in public policy, don't have the same needs and often don't identify with the severely ill. Organizations like NSSS, which do speak for the severely ill, have a continuing battle on their hands.

We will be going into this whole matter in more detail in subsequent issues.

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.