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Vancouver Coastal Health ducks the main issue

Vancouver Coastal Health, in a review of the death by suicide of Marek Kwapiszewski, has sidestepped the main issue they needed to address: Why is "dangerousness" all too often considered a requirement for involuntary admission rather than "to prevent the person's... substantial mental or physical deterioration," as spelled out in the Mental Health Act?

Kwapiszewski, 54, of Vancouver, who suffered from schizophrenia, jumped off the Granville Street Bridge to his death June 29, 2008.

His sister, Halina Haboosheh, together with her lawyer, had made 16 different attempts to get him the treatment he needed – treatment which required involuntary admission since Kwapiszewski, like many suffering from schizophrenia, did not have insight into his own condition.

The North Shore Schizophrenia Society took up the case, beginning with a lengthy submission to Vancouver Coastal CEO David Ostrow, June 2009.

The VCH review, which reported more than a full year after it was commissioned, simply ignored the underlying problem: that many service providers either don't know what the Mental Health Act says or ignore it if they do.

The review instead came up with an "action plan" that ironically involves no action at all.

Two of the three brief items in the plan, one on communication with the police and the other on guardianship were boilerplate, with nothing new in them and skirting the main problem.

The one item in the ostensible plan that even indirectly related to the clinical failure in the Kwapiszewski case wasn't much more useful.

It talked about working with other health authorities "to facilitate a discussion to consider development of an operational definition of 'deterioration' and 'in need of protection'" as used in the Mental Health Act.

Unfortunately, "to facilitate a discussion to consider development" of something isn't a commitment to actually do anything. It also shows a complete absence of any sense of urgency. Over and above that, the item begs several questions.

Aren't psychiatrists, psychiatric nurses and case workers supposed to already know what the language of the Mental Health Act means and why it's there?

Psychiatrists, for example, have not just their medical degrees and their year of internship but also three or four years of psychiatric residency and probably, on average, a couple of decades of experience. It shouldn't be beyond them to know what "substantial deterioration" means or what kind of help is needed by somebody who is ill.

Ms. Haboosheh, a lay person, trying to get her brother into treatment, certainly knew, and all the signs were there.

It's unlikely, too, that a long and desultory discussion by the health authorities is going to do anything except reflect the problematic culture of those authorities to begin with and provide rationalizations for not making necessary changes, including management changes.

"The 'action plan' should have been called an 'inaction plan,'" commented NSSS president Herschel Hardin, in a news release on the review. "It was as if a review had not taken place."

NSSS calls for measures to directly address the problem

In response to the failure of the Vancouver Coastal review to address the main problem behind Marek Kwapiszewski's death, NSSS put forward four recommendations of its own, to try to ensure that something meaningful is ultimately done.

The leading recommendation is to establish with all clinical personnel, through a series of workshops, the broad, proactive character of Section 22, the clause in the Mental Health Act on involuntary admission, and why the clause is worded the way it is. The wording in Section 22 wasn't just pulled out of a hat. It was the result of long deliberation and a recognition of compelling need – the need of people who are ill and deteriorating, but who don't have insight into their illness, to receive clinical help to deal with their psychosis.

Only by treating the illness, moreover, can the terrible suicide toll of the mentally ill be reduced.

The second and third NSSS recommendations call for involving family members as integral members of the treatment team and for the sharing of clinical information, respectively.

The final recommendation is for major changes in senior management of Vancouver Community Mental Health Services in keeping with the major change in culture implicit in the other recommendations.

NSSS holds the view that a major shake-up of management is necessary, given the entrenched systemic problems on these several key issues.

While Vancouver Coastal has promised to look at the recommendations, there is no indication as of press time what action on them might be taken.

Kwapiszewski case details available on NSSS website

Details of the Kwapiszewski case are available at the NSSS Media Centre, www.northshoreschizophrenia.org/media.htm.

Perhaps the most important of the documents is the original NSSS submission on the case, June 26, 2009, with its account of Marek Kwapiszewski's clinical history based on the medical records, the police reports, and his sister's notes.

Also included are NSSS news releases, a critical analysis of VCH's so-called action plan, and links to coverage of the affair in the Vancouver Sun.

Internal reviews not likely to bring necessary change

The Vancouver Coastal review of the Marek Kwapiszewski case serves as a reminder of how restricted, and often evasive, internal reviews by health authorities are.

Even when the review is nominally an "external" one, the same limitations apply.

In the Kwapiszewski case, Vancouver Coastal retained an external lawyer to head up the review and do the interviewing and an external psychiatrist as a clinical consultant. This was in response to an insistence by NSSS that the review be independent of VCH personnel.

In the breach, though, any purported independence on the part of the review team was forfeited. Instead of bringing recommendations forward independently, they met at the end with senior mental health managers and delivered what they described as a "consensus" report.

They did so even though those very same managers and their responsibility in the affair were supposed to be subjects of the review.

Also involved in the wings, in the Kwapiszewski case, was Vancouver Coastal's risk management officer, whose mandate is to minimize risk to the health authority. In practice this seems to mean never admitting that Vancouver Coastal could be at fault, even when the time for taking legal action against the authority has expired.

This means, in turn, any resolution for aggrieved or grieving family members is impossible.

NSSS has had previous experience with this problem.

In one case, involving questionable practices by a psychiatrist in North Shore community mental health, NSSS had painstakingly filed a detailed submission, with specific problems that needed to be addressed. What came back were condescending rationalizations that did not address the specifics at all. NSSS was given to believe the response had to be written that way. Why in that case should anyone bother making a submission to begin with?

Risk management is antithetical to accountability and honesty when faulty practice has been involved, and without that accountability and honesty, any review is tainted.

Standard reviews, done by quality improvement committees, have much the same limitations.

Quality improvement committees take the approach that they're not out to blame people. That would only devastate morale. Besides, everybody makes mistakes, and unexpected circumstances can confound the best of intentions. The committee looks to improving practices the next time around instead.

In many cases, this makes a lot of sense. You can't, though, improve practices without honestly identifying what went wrong, and if what went wrong was the result of a lack of professionalism or faulty clinical judgement, it needs to be faced.

This is easier said than done when a colleague is involved, especially when the colleague is a psychiatrist with a physician's authority. Deference, rather than vigorous inquiry and accountability, is likely to be the result.

Inquests are a better alternative, but often not a possibility

Especially for system failures, coroners' inquests are the best option for establishing cause and generating change.

Inquests are truly independent, with an inquest jury chosen from the population at large. People can be subpoenaed, and testimony is given under oath. The hearings are held in public, so that everyone can hear the evidence and what is said – and can also see what isn't brought up that should have been.

Further, questions can be asked of witnesses. A grieving family, moreover, may be given standing and can ask questions of witnesses themselves or have a lawyer represent them. Organizations with expertise and an interest in the case can also apply for standing.

This is quite a bit different from internal or quasi-internal reviews. In the Kwapiszewski case, interviews were done by the lawyer, to provide solicitor-client confidentiality. Without that, the VCH service providers in the case would clam up, as there was no power of subpoena and obligation to testify.

As a consequence, nothing the review found, all of it directly and indirectly tied to that confidentiality, was shared with Ms. Haboosheh (the victim's sister), NSSS, or the public. The non-disclosure included the conclusions of the review – if, that is, there were any formal conclusions.

The only thing disclosed was the brief three items of the "action plan."

Oversight of the review, then, was never a possibility. Needless to say, too, Ms. Haboosheh and NSSS had no opportunity to ask questions of the service providers themselves and test their version of events.

Inquests, by contrast, bring things into the light of day. They aren't, however, necessarily perfect. Ill-advised coroner's counsel may object to questions that cut too close to the bone, arguing that inquests are not meant to assign blame, and just as often the coroner will go along.

Where faulty practice or sheer incompetence is the primary cause of the tragedy being examined, however, only probing questions touching on individual decisions can get at the root of what has happened and why.

When, on the other hand, the coroner understands the need to look at everything openly, the advantages of an inquest become apparent. This was the case with the Ross Allan inquest in 2009, involving a suicide at MSA hospital, where the jury came up with a record 43 recommendations.

Unfortunately, inquests are so relatively expensive and time-consuming that requests for an inquest are not always granted. Further, where no death is involved, an inquest would not apply, although the issues in the case might be extremely important.

"Internal review," "independent consultants," "quality improvement committee" all sound good, but in practice, under the umbrella of a health authority, they have severe limitations and cannot be relied on. Inquests, meanwhile, are not always available.

Advocates for the mentally ill and their families have their work cut out for them.

FEEDBACK WELCOME

We welcome your comments on anything you read in the *Advocacy Bulletin*. Call us at 604-926-0856, mail us a note at the Family Support Centre, or send us an email at advocacy@northshoreschizophrenia.org.