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Coroner's report a wake-up call for practitioners

"More robust and intensive community care," is needed in cases of people with a serious psychiatric illness who also suffer from acute or chronic physical illness, according to Scott Fleming, Vancouver coroner.

The wake-up call for psychiatric practitioners is one of his many recommendations in a report looking into the death of Ben Williams of North Vancouver December 2009.

Ben died of a seriously deteriorating heart condition when a Community Psychiatric Services (CPS) psychiatrist declined to involuntarily admit him to hospital despite Ben's profound lack of insight into his situation and a paranoid distrust of doctors which made him loath to seek treatment.

In the weeks before his death, he had difficulty getting out of bed, wasn't keeping up with his hygiene, was losing bowel control, and couldn't walk more than 10 steps without stopping for breath, yet the provision in the Mental Health Act to get him into hospital – involuntary admission "to prevent substantial mental or *physical* deterioration [italics ours]" – wasn't used.

Fundamental clinical error

Details reported in the coroner's investigation confirm this fundamental clinical error, noted earlier by NSSS in its submission on the case to the Chief Coroner of B.C. which led to the investigation being undertaken.

The investigation also revealed a breakdown in integrated treatment for someone with both a serious mental disability and an equally serious physical illness.

In the spring of 2009, six months before his death, Ben had been committed, by a different physician, to ensure treatment for his heart condition and breathing difficulties. He was required, by his subsequent discharge summary, to follow-up with an internist.

He never did – not surprising given his antipathy to doctors and hospitals. This was ignored.

Ben's general practitioner, meanwhile, who could have been of more help had he been given the discharge summary, was not sent a copy.

Fleming notes in his report, that the problem of lack of insight (caused by mental illness) combined with physical deterioration is becoming more and more common.

A long way to go

The considerable, and appreciative, attention given to our special edition on information sharing November 2010 was encouraging, but also underscored how far psychiatric practice in B.C. has to go in understanding the issue.

When a patient gives permission for clinical information to be shared with family members, the issue doesn't arise. It's when permission isn't granted because the patient doesn't have insight or is paranoid that the questions comes up.

The *Bulletin* feature spelled out in detail that not only can the information be shared with family members in such circumstances – without the consent of the patient – but that clinically, and to avoid tragedy, it also *should* be shared.

In one instance, a senior manager in mental health services took the Bulletin to a lawyer and asked him if our explanation of the Freedom of Information and Protection of Privacy Act was correct. He assured her that it was, after which she distributed copies of the *Bulletin* to her staff.

Good for her, for taking this initiative.

Of course, we knew FIPPA allowed this information sharing. We've been speaking out about this issue for a long time. What does it say, though, about the training of mental health workers in B.C. that learning about something so basic depends on NSSS or, for that matter, consulting a lawyer?

We know, too, that most people in psychiatry and mental health services in B.C. still are ill-informed on the issue.

Let's hope that finally, somehow, efforts will be made to bring everyone up to speed.

He makes several recommendations for a broad-based educational initiative on the subject, beginning with a multi-disciplinary case review of Ben's death and the adoption of a more robust and intensive community care component, similar to Assertive Community Treatment (ACT), for such cases.

The recommendations are addressed to Vancouver Coastal Health, the College of Physicians and Surgeons, and UBC Continuing Professional Development.

The coroner's office, in its investigation, also went to considerable pains to confirm the account of the case originally provided by NSSS and, with access to the medical records, to provide much added detail.

Crucial matters left hanging

Partly because of the limitations of the coroner's function, however – a coroner cannot find fault – some crucial matters arising from the case went unaddressed, namely the individual failure to use involuntary admission, although it was clearly called for, and a parallel failure to work closely with key family members.

These matters, moreover, lie at the heart of chronic system failure by Vancouver Coastal Health in all too many cases.

The psychiatrist involved, in addressing the question of involuntary admission, told the coroner, "We were trying to follow a more trusting, autonomous view of treatment."

Depending on trust, however, when the patient has little or no insight and is in dire medical need is a fundamental clinical error.

Indeed, in the spring, when involuntary admission was used with Ben, and necessarily so, the clinicians at the time were quite clear about the circumstances.

The physician who certified him, the coroner reported, "identified his delusions which directly affected his ability to understand the nature of his illness and make logical decisions about his physical and mental health."

A second physician noted that Ben "was at significant risk of immediate medical complications, including respiratory decompensation and death, without supervised medical care and urgent psychiatric assessment to determine competence for self-care."

Seven months later, after involuntary admission was spurned by the psychiatrist then in charge of the case, the patient was dead.

The second key factor, not discussed in the coroner's report, was the failure of the clinician to work directly with family members as an integral part of the treatment team in the months leading to Ben's death.

Had the psychiatrist done so, and given their observations adequate weight, he would not have so seriously misread the situation.

The coroner himself doesn't appear to be aware of the importance of family involvement as part of the treatment team in cases of mental illness. Nowhere in his highly detailed account and his conclusions does he address that facet of the case, nor in his recommendations does he include an organization representing families among the groups to be involved in the education and teaching initiative he proposes.

NSSS knows from experience that without this representation, a lot of key factors are going to be overlooked or downplayed, if not swept under the rug altogether.

The full coroner's report is available on the NSSS website at www.northshoreschizophrenia.org/media.htm.

For NSSS's original coverage of the case, please see the Bulletin's April 2010 issue.

"Physical deterioration" an often ignored clause

As the Vancouver coroner noted in the Ben Williams case, the way that lack of insight, because of psychiatric illness, affects judgement about physical illness is going to be more and more of an issue in psychiatric practice and also in other medical disciplines.

The involuntary admission section of B.C.'s Mental Health Act fortunately already makes provision for getting the person into hospital, with its key clause, "to prevent substantial mental or physical deterioration." (For treatment of the physical illness, the Health Care Consent Act can then be used, if the person remains unable to understand the nature of their illness and make competent decisions about it.)

Not so fortunately, the "physical deterioration" criterion for using involuntary committal, where appropriate, does not get the attention it deserves.

Heart disease, diabetes, infectious skin conditions (especially of lower legs and feet) and severe anorexia all come to mind as applicable.

Those aren't the only relevant situations, however. NSSS knows of a case where a mentally ill person was in danger of losing an eye because of a detached retina. The eye could be saved by surgery, but the patient, lacking insight and not wanting the doctor to perform surgery on him, resisted. No amount of pleading, coaxing, or explanation could free him from his fixed paranoid idea.

The eye surgeon, for his part, refused to do the procedure without the patient's permission, even knowing he was mentally disordered.

The mother watched in agony as her son unnecessarily lost the use of his eye.

It's yet another difficult situation that medical practitioners in B.C. need to sort out.

Mother wins case in Canada's Tax Court

It's not often, or ever, that the Tax Court of Canada hears a discussion of what mental illness means to family members, but that's what happened in the court January 20 in Vancouver, with Justice Frank Pizzitelli presiding.

The occasion was an appeal by NSSS member Hedy Theed of a Canada Revenue Agency decision to reject her claim for the caregiver's allowance, for the caregiving of her ill son.

In the end, the court came down on Ms. Theed's side.

For Ms. Theed to qualify for the claim, her son's "ordinary place of residence" needed to be the same as her own in the applicable year (2008). The term, however, is not defined in the Income Tax Act, in order that circumstances can be taken into account.

The CRA denied the claim because Ms. Theed's son slept at a different address. He did so, however, only because Ms. Theed lived in a studio apartment, one room in effect.

Sleep aside, every morning on waking her son went to his mother's place, using his own key when she was at work. When she returned, they were together until the end of the evening. They were also together weekends. All the other things involved in caregiving, from washing clothes and looking after hygiene through to making meals and trying to ensure her son made his appointments, were present as well.

Both Ms. Theed and NSSS President Herschel Hardin, as an expert witness, provided background on how much stress, worry and effort was involved in this caregiving because of the nature of her son's illness.

The CRA's lawyer maintained that where the young man slept was his "ordinary place of residence." It was his mailing address, at least technically, and had a stove, kitchen, shower and other facilities, whether he used them or not (he didn't).

Ms. Theed disagreed with the CRA's contention. Almost all her son's waking hours were spent at her place, she explained. The only reason he slept elsewhere was because she didn't have a big house with extra bedrooms. Should she be punished for that?

"Is somebody's home where he sleeps or where he lives?" she asked the court.

Justice Pizzitelli granted her appeal.

There probably aren't that many similar situations at any one time in Canada. Most families would have a separate bedroom for someone they were looking after, and if the ill person couldn't live at home, it's unlikely they would be spending so much time there. The court's decision set only a limited precedent.

Nevertheless, a precedent it is.

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.