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Emergency service needs a serious rethink

Mental Health Emergency Services (MHES) in Vancouver is supposed to pro-actively help the severely mentally ill, but its own mission statement gets in the way

Judging by the 2009 statement, "Moving Forward with Quality Mental Intervention," you would think the last thing they wanted to do was to get someone into hospital for treatment, especially if it required involuntary admission.

Most severely ill people, however, don't have insight into their illness – they suffer from "anosognosia," to use the clinical word – so not using involuntary admission can leave them to the predations of their illness, with often tragic consequences.

The North Shore Schizophrenia Society accordingly, in an email February 11 to Vancouver Coastal Health's CEO David Ostrow, has asked Ostrow and his quality improvement chief Patrick O'Connor to change the MHES mission statement before it does more damage.

The key paragraph in the statement, or self-description, begins as follows:

> The goal of MHES 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.

This reference to "minimizing admissions to hospital emergency departments" militates against hospital treatment, although hospital acute care is a key part of helping the seriously ill and is certainly so for urgent situations.

More troubling is the sentence, "Staff uses the least intrusive resolution to the situation *while maintaining the safety of the person with a mental illness and the public* [our italics]."

This statement effectively says that if the person's safety is maintained – if there's no dangerousness – then we don't think of involuntarily admitting them, although they may be seriously deteriorating, have no insight into their illness, aren't taking medication, or their physical health may be in peril.

It similarly ignores the intention of the Mental Health Act, which calls for involuntary admission, where necessary, to "prevent substantial mental or physical deterioration."

It also glosses over the fallacy of using dangerousness as a clinical requirement. Someone who is severely ill can change from being "safe" to being dangerous in the blink of an eye if the underlying illness isn't dealt with, and then it's too late.

This is what happened in the notorious Marek Kwapiszewski case, where MHES, despite multiple appeals by his sister, declined to intervene with involuntary admission because he wasn't considered dangerous, and he then plunged to his death from the Granville Street Bridge.

The severely ill aren't in the end even protected from danger. The whole purpose of MHES is defeated.

Use of word "community" hides the real problem

The MHES mission statement goes on to say:

> This program's philosophy reflects the belief that people with a mental illness should be treated within their community whenever possible.

Treatment in the community sounds nice, but what does it actually mean in practice?

The reference is presumably to treatment by a community mental health team as different from acute care, although hospitals are also part of, and in, the community.

Such treatment "in the community" is fine for people who understand their illness and the need for treatment, in which case MHES outreach can facilitate a prompt and timely connection to a mental health team, and treatment subsequently follows. For others, though, who suffer from paranoia and lack of insight, it is clinically wrong-headed, as the person will reject treatment.

Finally, the mission statement goes on to say:

> Early intervention often reduces unnecessary admissions to hospital and can lead to a better overall prognosis for the course of the current illness.

In practice, however, for those who have no insight, the opposite of early intervention happens. MHES waits for dangerousness to be evident, which means often letting the course of the illness proceed well into substantial deterioration and worse.

We are familiar with a case where someone was quite psychotic, and the MHES response was, "He's not there yet." He was more than there, however, in terms of the need to prevent further deterioration and the corresponding need for treatment.

This became more than clear when, with the help of NSSS advocacy, he was belatedly escorted to hospital and involuntary admitted. Asked by us the following morning how he was doing, the ward nurse blurted, "He's very psychotic," as if we were stupid to have even inquired. Any psychiatric team genuinely pledged to early intervention would have brought him to hospital long before.

A proper MHES mission statement would read something like the following:

> The goal of MHES is the provision of a rapid response to urgent and emergent mental health situations, actively using the provisions of Section 22 to prevent substantial mental or physical deterioration as required, realizing that for someone who is severely ill, treatment in acute care is usually the best possible first step. The leading rationale, and

mission, of MHES is to do this outreach where the ill person lacks the insight into their own illness and will not present themselves to a treatment facility on their own. In other cases, where there is insight and where the illness or relapse doesn't yet foreshadow substantial deterioration, using secondary means and arranging for treatment by a community mental health team are an option, but in all cases, timely intervention and treatment are the objective.

Scrapping the MHES 2009 statement is not only desirable in itself, the exercise would also oblige MHES to do some serious soul-searching about its approach.

Vancouver Coastal has yet to reply to the NSSS February request that the statement be revised.

What's in a name? More than imagined

In the Fall 2010 issue of *Catalyst*, the newsletter of the Treatment Advocacy Centre in the U.S., renowned psychiatrist E. Fuller Torrey dissects the misuse of various names for those with schizophrenia and, by implication, those with other serious mental illnesses.

Patients? Clients? Consumers? Survivors? People With Lived Experience?

He ends up disqualifying all of them except "patients" or "clients" in certain circumstances – patients, when people have had treatment, and clients, inasmuch as they voluntarily seek services in, say, a clubhouse.

"People with lived experience" is faulty, since everyone has lived experience. Having an illness, moreover, isn't merely an inter-changeable part of a spectrum of human experience.

"Carried logically forward," Torrey writes, the term "suggests that diabetes is not a disease but merely a 'lived experience' of having a high blood sugar level. In fact, the underlying intent of using most of these alternate terms for people with schizophrenia is to challenge the idea of schizophrenia as a brain disease."

"Consumer" doesn't work because it presumes choice (choice of mental health services is the idea), whereas half or more of those with schizophrenia aren't aware of their illness and hence how they might choose to deal with it, and nobody chooses to have the illness to begin with.

Torrey himself prefers "people with schizophrenia," because it is inclusive and scientifically accurate. For the complete article, please go to www.treatmentadvocacycenter.org, Browse Resource Library, Catalyst Newsletters, Fall 2010.

Fuller Torrey is the author of *Surviving Schizophrenia* and many other books on mental illness, chair of the Treatment Advocacy Center, and head of the Stanley Medical Research Institute.

Canada has its own odd naming idiosyncrasies

Fuller Torrey's concerns are similar to those long held by NSSS.

Euphemisms like "consumer" are intended to protect those with a mental illness from stigma, but they have the opposite effect. They imply that schizophrenia, or bipolar disorder, or depression, are so shameful they cannot be openly described.

They also trivialize these illnesses and trivialize the difficult struggle and enormous courage of the severely ill in coping with them. After all, if it's only a matter of consuming something or having an unnamed experience, what does it count for?

Such misdescription also detracts from the reality of mental illness – that such illnesses are diseases of the brain requiring medical treatment and other clinical help.

The euphemisms Torrey identifies, like "consumer" and "people with lived experience," are also used in Canada. There are others used here as well.

One of the most prevalent is "mental health issues," as in, "John has mental health issues," instead of, simply,. "John has schizophrenia" or "John has bipolar disorder," for example. "Issue," of course, means a question that is in dispute and is settled by debate and discussion, altogether the wrong word for this purpose.

Somewhere along the line, though, service providers (psychiatric nurses, case workers, etc.), began using "mental health issues" as if they had been warned that straightforward, meaningful descriptions, like "mental illness," were taboo.

The police and media have followed, although occasionally someone will admit in private how inapt the use of "mental health issues" is.

Sometimes the irony of it – language that's meant to help but only hinders – can be quite biting. In a CBC interview earlier this year, a young man cited "mental health issues" instead of "mental illness" to explain why his ill brother, under the force of paranoid delusions, had killed a couple of people. The vague and euphemistic language only impeded understanding.

A recent item in the Vancouver Sun referred to a woman's "struggles with mental health." The phrase "mental health treatment" also occasionally crops up.

NSSS has even heard "mental health disease" used.

Evasive language almost inevitably begins to contradict itself.

NSSS, for its part, continues to use open and meaningful language for mental illness.

We use "patient," where applicable, or "He has schizophrenia," or "She suffers from bipolar disorder."

For general descriptions, we use "mental illness" – often "severe mental illness" or "serious mental illness" to make things clearer – or "suffering from a mental disorder" when there's a legal context.

The name on our door, of course, and on our street banner, letterhead, advertising, and charitable receipts is the "North Shore Schizophrenia Society," certainly not the "People with Lived Experience Society."

We use clear and meaningful language expressly to combat stigma – to let people know there is no shame in having serious mental illness, no more than in having diabetes, cancer or any other biologically based illness.

Most of all we do it to focus on the idea that we are dealing with a brain disease, not some vague "issue" that can be talked through, and that such illness requires appropriate medical treatment and other clinical help if the person is going to get back on their feet.

FEEDBACK WELCOME

We welcome your comments. You can either call us at 604-926-0856, drop by the Family Support Centre, or send us an email, at: advocacy@northshoreschizophrenia.org.