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Lack of capacity or lack of accountability?

Is the problem of mental health services in Vancouver and elsewhere in the Lower Mainland a lack of capacity or a lack of accountability….or is it both?

A previously uncirculated 2010 draft report on mental health services from the Vancouver Police Department, "Policing Vancouver's Mentally Ill: The Disturbing Truth," goes part way in providing an answer.

The report, leaked to CBC News just this past September, was a follow-up to the VPD's earlier 2008 inquiry, "Lost in Transition: How a Lack of Capacity in the Mental Health System Is Failing Vancouver's Mentally Ill and Draining Police Resources." The 2008 document caused a sensation because of its frank look at an intolerable situation.

The new report, written two years later, found that not much had changed in the interim.

The report acknowledged some progress has been made with supported housing and with the opening of the Burnaby Centre for Mental Health and Addictions for concurrent disorder patients, with intermediate stays of up to 12 months.

For the rest, though, there was little to cheer about.

"The police," the report noted, "are still responding day after day to 'difficult to manage and treat' chronically mentally ill and addicted individuals on the streets of Vancouver.

"Other issues relating to suicide, suicide attempts and missing persons consume police resources, frustrate police, and in some cases endanger the lives and safety of patients, front-line police officers, other first responders and the public. …

"The attempts of the police to solve these 'problems' are still being hindered by the barriers of information sharing, a lack of system capacity and a lack of apparent will on the part of the health system in Vancouver to adapt and change."

The VPD, in so many plain-spoken words, was pointing to management failure at Vancouver Coastal, which isn't the best way of making friends. It's understandable, then, they didn't make the report public, but shared it privately with Vancouver Coastal instead, as part of an effort to establish more cooperation and responsiveness on the part of the health authority.

This seems to have produced some results. Police waiting times in Emergency are being reduced. Joint committees have been set up so problems can be addressed together.

If the 2010 report were written today, it wouldn't be quite so critical and sound so exasperated – would, perhaps, even allow for optimism.

Major difficulties, however, remain.

Beyond lack of capacity is a deep-seated issue even more troubling

There is no doubt that, as mentioned, lack of capacity is part of the problem. With the phasing out of Riverview, there needed to be a corresponding increase in intensive community-based care, and that hasn't happened.

The relatively new Burnaby Centre for Mental Health and Addictions (BCMHA), for example, has 100 beds….and a waiting list of more than 300 people!

Another option is assertive community treatment (ACT), which involves around-the-clock teams of 12 people providing intensive care and supervising medication – a "hospital without walls," as it has been described.

Vancouver Coastal Health is only now, very belatedly, addressing this need, with steps being taken to have a proper ACT team in place by January. Another ACT team, in the downtown Eastside, operated by RainCity Housing, is currently in place as part of Mental Health Commission of Canada's At Home/Chez Soi housing project, but it winds up in early 2013 unless replacement funding can be found.

Then there's the back-up in acute care wards. At Lions Gate Hospital on the North Shore, for example, quite ill patients are sometimes housed temporarily in Emergency or on occasion even sent home, although certified, awaiting a bed in acute care.

If insufficient acute-care beds and intensive community treatment were the only problems, the situation for the seriously ill would still be deeply troubling, but the VPD report, indirectly, raises another question which perhaps gets closer to the heart of the matter, namely the lack of accountability in mental health services.

The report describes how the police, through Car 87 (emergency services), identified a group of 19 people who were already receiving some treatment services from the community and were ill enough to be considered for possible referral to the Burnaby (BCMHA) centre.

The VPD subsequently discovered that mental health services had closed all of the files.

In the meantime, in not much more than a year overall, the 19 people had run up 619 police contacts for both criminal matters (suspected, chargeable, or in the end charged) and mental illness incidents.

Five of the 19 were themselves victims in that period, in incidents including assault, assault with a weapon, uttering threats, and robbery with a weapon.

The closing of files of people who are still quite ill, often because they don't show up at their community mental health team – disregarding their lack of insight, inability to organize themselves, or alienation – isn't new. It has long been an NSSS concern.

The VPD report also catalogues a long list of suicides and suicide attempts resulting from system failure. In one case, a person committed suicide the same day he was released from hospital, in another case while on a two-hour pass.

The problem of "walk-aways" from hospital of people who are certified is also highlighted.

What concerns the VPD most in all this is the absence of "a more public and transparent review process regarding medical practice in this area," by which attending physicians can learn from a patient's suicide and the circumstances surrounding the death.

They compare mental health services' casual attitude to walk-aways with their own delayed response to a suicide incident where there was a public admission of fault and discipline of two VPD field supervisors.

This absence of a more public and transparent review process is the nub of the problem.

To learn from tragic incidents or system failures, you have to take a frank look at what happened and, if there was sloppiness or clinical misjudgement, admit to it as a stepping stone to improving practices.

The review also needs to be done openly to assure everyone concerned that an effective review has taken place and those doing the review don't hide behind defensiveness and rationalizations.

This doesn't happen. While a transportation board review of a plane crash may find pilot error, or a police review end up with disciplinary procedures, such understanding of responsibility doesn't occur in mental health services.

The basic review process in mental health services is handled by a "quality improvement committee," usually only if a complaint is filed.

The committee rarely if ever finds fault or acknowledges even the smallest degree of error, at least not publicly, and its response to the complainants, in NSSS experience, is bureaucratic boilerplate. It generally avoids addressing particulars and disclosing findings, using as an excuse that doing so would betray the confidence in which interviews were conducted.

Even in highly disturbing cases – say, four unnecessary deaths in a pattern, with the same psychiatrist involved and with some quite egregious behavior – nothing close to a disciplinary measure takes place.

The public is left wondering whether a review of any rigour took place at all. Too many questions go unanswered.

The proceedings and results of less formal VCH "debriefings" after tragic incidents also go undisclosed, with no assurance they actually took place, much less that there was any thoroughness and honesty to them.

Vancouver Coastal Health Authority doesn't seem to realize the damage this does to its own operations. Without the accountability of a more transparent review process and the discipline it provides, problems can continue to be ignored and faulty practices and bad judgement, leading to tragedy, can repeat themselves.

The health authority and its managers also lose credibility.

People are discouraged from providing feedback. Why go to the trouble of submitting a complaint, with the care and documentation that's often involved, when the only apparent response is a brush-off?

This means in turn that mental-health managers aren't even going to be aware of a lot of problems that occur, much less fix them.

The VPD in its report, somewhat with reluctance, is driven to ask for the coroner to get involved, at least in a narrow band of cases – in suicides where an individual received treatment within a 30-day period before their death.

This is a limited, imperfect solution at best, even if the overburdened Coroners Service were able to oblige. The whole question of lack of accountability in mental health services needs to be opened up.

Inadequate capacity is only part of the problem in the mental-health system.

Changing Her Mind

The most moving aspect of Margaret Trudeau's most recent book, *Changing My Mind*, is how long it took her to accept her bipolar disorder and move on from there, almost thirty years after symptoms first showed themselves.

In a book of 345 pages, it's not until page 271 that she gets there, and not until page 290 that she writes, "I was beginning to discover that a person with a mental illness does not have the ability to understand what is going on."

Up until then in the story, at the age of 52, her life was a roller coaster – a bright, beautiful, courageous woman struggling with her highs and lows and, in the telling, filling us with compassion at how hard she tried and with awe at her lust for life and her many disasters.

Finally, on a December day in 2000, after her son Sacha and the police had been desperately trying to find her, she was taken to hospital strapped to a gurney, not without first fighting and shouting.

The depression and mania had been alternating at a frightening rate and she was hardly eating – "spiralling out of control…a train on the wrong track and moments from crashing," as she put it.

She wasn't quite accurate in saying those with a mental illness can't understand what's going on. She herself is a case in point, fully understanding when she reached her fifties and was adequately treated and stabilized. In an acute phase, though, and sometimes for decades of denial, self-pity and anger, the insight isn't there.

She was a case in point for that, too.

The other memorable aspect of the book is the role her family and friends played in keeping an eye on her and in taking action.

One friend, at the time of Margaret's acute 2000 episode, kept calling and calling, and when she didn't get an answer for several days, knocked on Margaret's door and kept knocking, until she finally responded. Then the friend went out of her way to contact Margaret's son Sacha, who was also in Ottawa.

Another friend played a similar role when Margaret promptly "eloped" in an attempt to avoid hospitalization.

Sacha, meanwhile, didn't hesitate to call the police in order to try to find her and get her to Royal Ottawa Hospital.

We can imagine readers at large being mesmerized by Margaret's unsparingly honest account of these and other events in her journey. For those who have been ill themselves, on the other hand, and for those of us with an ill relative, her story is also our story, achingly familiar.

That she tells it so vividly and that, as a former prime minister's young wife, she has such a high profile, is something we can be thankful for. She brings home the reality of mental illness; let's people know what it's really like.

FEEDBACK WELCOME

We welcome your comments. Please call us at 604-926-0856 or email us at advocacy@northshoreschizophrenia.org.