NSSS ADVOCACY BULLETIN
Vol. 4, No.4 March 2012

Seemingly small failures can mean large setbacks

Small failures in mental health services may not seem serious in themselves, but they can mean large setbacks for the mentally ill and punishing stress for their families.

They can also have tragic consequences.

To add to the situation, there's no effective mechanism in place for fixing these problems and raising the level of competency.

NSSS frequently hears about such incidents of failures of detail, some of them hard to believe.

Many of them could be categorized as shoddy clinical practice or, sometimes, just mind-boggling.

Here are a few examples.

- A very sick young man, in the new tertiary facility in Vancouver, who had improved in Riverview, is deteriorating again. The man's relative asks if he is actually taking his medication. Have they taken blood levels to check on this?

She knows her son thinks he doesn't need medication because he's not ill. He's told her so.

The blood levels are fine, the relative is advised with considerable condescension. They're looking after it. He's a big boy. They don't have time to treat him like a baby and grind up his medication. They give him the pills in his hand and a glass of water.

The blood levels, it turns out, are not fine. He hasn't, in fact, been taking his medication for two months, ever since he arrived at the ward.

Clinically speaking, he might as well have been out on the street.

- A woman calls Emergency at Lions Gate Hospital and explains to the Psychiatric Emergency (PEN) nurse that her daughter is off her medication and is becoming psychotic again. The ill person is on extended leave where she is in the community but still certified.

The nurse tells the mother to call the police. That, however, would be useless, as the ill person isn't "likely to endanger" (the police requirement). She is just becoming very ill again.

The mother, who has more sense, seeks out the daughter's psychiatrist instead. Because the daughter is still certified, he simply signs a warrant to have her brought back to hospital. This is exactly how extended leave is supposed to work.

The nurse should have known the process and acted accordingly.

Lack of basic understanding baffles family members

Sometimes the failures betray a lack of understanding of how severe mental illness affects people, as basic as that is. This is baffling for family members. How could supposedly well-trained service providers not understand, and properly take into account, the obvious?

- A mother contacts mental health services in the Okanagan about her daughter, to inquire about outreach. She's told by the intake nurse that the young woman, suffering from schizophrenia and without the slightest insight, has a right to make her own decisions (even if it leads to her living on the street). She can be as psychotic as she chooses, the intake nurse says.
- Community Psychiatric Services (CPS) on the North Shore closes the file of a woman suffering from major depression because she didn't come in for an appointment.

Of course, she didn't come in because…well, because she was suffering from major depression. She could barely get out of bed, much less cross town for a rendezvous with case workers.

It's not the first time CPS has closed files because people haven't come in, without taking into account how illness affects behaviour and without adequate outreach to make contact.

- A mother wants to pass on observations about her ill son to the Midtown mental health team where he's a patient, but wants assurance they won't say anything to her son, who is paranoid. She's afraid that telling him will drive a wedge between them. Given what she takes to be that assurance, she discusses some of her son's history with the team worker.

The worker then tells the son his mother has been talking to them, with predictable results.

The mother is so bruised and shaken, she doesn't have the courage to call them again, even when she knows there are things they should be taking into account.

- A clinical team asks an ill boy's relative to explain unusual behaviour on his part. When she refers to certain delusions and fears he has told her about, they riposte, "Why is he telling you that? He should be telling us." They talk as if the whole family is to blame for his not doing so, ignoring that he's paranoid and won't confide in hospital staff.

Paranoia and fearfulness, needless to say, aren't exactly novelties in serious cases of schizophrenia. It's why collateral information, especially from a close family member, is meant to be given weight and taken seriously, and why family members should be encouraged to pass on their observations.

One can't help asking, "Don't these service providers know how serious mental illness works?"

Not sharing information remains a serious problem

Service providers also regularly fail to share information with family members when a patient is paranoid and won't give permission, which, because of the psychosis indicated, is exactly when the sharing of information is so crucial. B.C.'s privacy legislation expressly allows for the sharing of information in such circumstances.

• The Midtown mental health team, citing confidentiality restrictions, refuses to tell a mother anything about her son, although she is a key source of understanding. Their explanation is wrong in law and clinically damaging.

This isn't unusual. All kinds of service providers in B.C. also get it wrong, astonishing as that is. At one point, however, the team dismissively tells the mother that even if her son dies, they can't tell her about it. This takes the award for silliness.

• A woman, after her parents die, wants to brief herself on her ill sister, of whom she has become the caregiver. The case worker at the mental health team replies categorically she won't talk to the woman. "Sisters shouldn't be involved in this," she says.

Leaving aside that family involvement is best practices, the response is more than a little bit outrageous.

(For a full discussion of information sharing, see the November 2010 issue of the *Bulletin* on the NSSS website.)

Condescension, pretension often plague attitudes

The condescension and dismissiveness that sometimes occur is hard for family members to take. Many service providers don't seem to understand the trauma family members have undergone and, in difficult situations, how much stress they're under already.

Even more troubling, the more that family members are alienated and discouraged by system failure – and the seemingly small failures can be brutal – the more difficult the course of recovery is for their ill relatives, because family involvement is so important.

Not sharing clinical information with families and diligently soliciting information from them is particularly disastrous. In a long list of cases involving unnecessary deaths which NSSS has made submissions on or otherwise documented, this failure to work closely with families was a major contributing factor.

The most egregious failure, meanwhile, is not understanding the provision for involuntary admission in the Mental Health Act – the key provision of the Act.

This brings us to our final illustration:

• A woman takes her daughter-in-law to Emergency at Lions Gate Hospital. "She's not a danger to herself or others," the PEN nurse tells her. "That's the criterion for admission."

This comes just a few months after Vancouver Coastal Health's special workshop on the Mental Health Act, where it has been made clear that dangerousness isn't required for involuntary admission; that the prevention of substantial deterioration is the leading criterion.

The workshop was mounted because of a tragic suicide in which Vancouver Coastal Health was found wanting exactly on this crucial matter of what the Act says.

The nurse, who should have attended the workshop – it was given three times, to accommodate every shift – either didn't get it or wasn't paying attention.

Rigorous mechanism for improving competencies not currently available

These are just some of a seemingly endless supply of such anecdotes from NSSS files, illustrating everything from an inadequate grasp of important details to ignoring in practice, or not quite knowing, how serious mental illness works.

In every case it means unnecessary suffering by the mentally ill and an unnecessary burden of stress and anguish for family members. All too often it results in needless tragedy as well.

Just as disturbing, there isn't in place a rigorous and effective way for service providers to learn from such incidents and improve competence.

Family members are frequently too afraid to make a point of any particular incident for fear of getting in the bad books of service providers and jeopardizing the way their ill loved one is treated in the future.

They also don't have in hand a sufficient range of cases to provide context, nor are they in the business of documentation and analysis.

NSSS, probably alone in British Columbia, tries tracking such incidents and the weaknesses in training and accountability that lie behind them.

It does bring up major failures, sometimes publicly. Important as this is, however, it's no substitute for those representing family involvement being an integral part of review committees and training, along with clinicians and case workers.

Mental health services, consequently, ends up perpetuating many of its own weaknesses, indefinitely into the future.

NSSS files request on St. Paul's case

NSSS, in a letter February 27 to Providence Health's CEO Dianne Doyle, has recommended support co-ordinator Marguerite Hardin be named to the projected review panel looking into the Mohamed Amer case.

Amer, 30, stabbed an elderly man in a Vancouver coffee shop after being taken to St. Paul's Hospital by the Vancouver Police twice the day before and being released by the hospital on both occasions.

The victim was a complete stranger to Amer, who almost certainly is mentally ill.

As of *Bulletin* press time, no response to the NSSS recommendation has been received.

The letter notes that NSSS has long experience in reviews, inquests, coroners' investigations and trials that have followed on the heels of grave incidents. It has found that without the participation of a knowledgeable family member as part of the inquiry team, any investigation will risk major shortcomings. The most qualified psychiatrists and lawyers handling such inquiries, moreover, may have significant gaps in their experience and understanding.

NSSS's critical observations are based particularly on the review of the Marek Kwapiszewski case by Vancouver Coastal Health (2009-10) and the investigation of the B.C. Coroners Service into the death of Ben Williams (2010).

Both inquiries, while having value, were handicapped by an absence of expertise in family involvement and the background on the relevant issues it brings to the table.

For more on those two cases, see "Advocacy Cases" on the NSSS website's Media Centre page.