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# *Repercussions of phasing out Riverview still hurting*

If the closing of Riverview Hospital in Coquitlam had been just a matter of moving beds for the most severely ill to different locations in the province, it might still have been a mistake, but it might not have done so much damage.

The final shutting down of Riverview, however, to be completed this summer, has been more than an administrative shuffling of beds to decentralize treatment and care. It represents the last chapter in a long and painful story of misunderstanding about serious mental illness and what those who are ill require.

It's led to the widespread conclusion that deinstitutionalization has been a failure, notwithstanding that the last phase, beginning in 2002, has been carefully planned following much criticism about the downsizing in the past.

According to B.C. Mental Health and Addiction Services, a branch of the provincial health authority, 926 replacement beds all told will have been created by July when Riverview will be closed altogether. This represents a one-for-one transition to more decentralized locations, going back not just to 2002 but to the early 1990s.

At its peak, in 1951, Riverview's patients and long-term residents totalled 4,630. The equivalent for today's population would be 17,163.

This doesn't mean we should have provided that number of tertiary beds today. Anti-psychotics, local psychiatric wards, and community mental health services have dramatically reduced the need for beds.

What's not in doubt, though, is that the level of treatment and care once available at Riverview has not been adequately replaced for many severely ill, with disastrous results.

Ministry of Health figures for psychiatric acute care, provided to NSSS in response to a request, give a hint of what has happened. They show the total of acute-care beds in the province has declined from 1,442 to 1,267 just in the eight years 2003-2011, with all of the decline being in the Provincial Health Services Authority, reflecting the diminished capacity at Riverview. This represents a reduction in acute care capacity of 12 per cent over all in absolute terms and of 21 per cent taking into account population increase.

This is for an acute-care system that was already overstretched by the previous wave of de-institutionalization, beginning in the early 1990s, and prior incremental downsizing in the 1980s when, seemingly out of the blue, substantial numbers of seriously ill people began appearing in the streets in the Downtown Eastside in Vancouver.

The upshot has been a back-up of ability to respond adequately, with ultimately the street, the police and the courts, and finally jails and prisons playing an increasing role.

The mental-health system has yet to catch up with the errors and indifference of the recent past.

## *Police time, prison figures highlight the consequences*

Other statistics fill in the picture. *Lost in Transition*, the Vancouver Police Department's 2008 study, found that 31 per cent of police incidents involved at least one mentally ill person, and in some areas of the city the figure rose to almost half.

The report was aptly subtitled, "How a lack of capacity in the mental health system is failing Vancouver's mentally ill and draining police resources."

The number of seriously mentally ill in jails and prisons is another marker. Estimates of the number of mentally disordered offenders currently in jails and prisons in Canada range from 15 to 40 per cent, depending on how "mentally disordered" is defined. Seriously mentally ill people make up to 20 per cent of the country's federal-prison population, double what it used to be only 15 year ago.

B.C. presumably has contributed its share.

In those prisons, incidentally, solitary confinement is often used as a stop-gap to deal with mentally ill offenders.

The capacity for intermediate stays in hospital (six months to a year) – a category where Riverview played a key role – also is inadequate. Intermediate stays are especially needed for those with concurrent disorder (substance abuse as well as mental illness).

The Burnaby Centre for Mental Health and Addictions was created to help fill that gap. The Centre has 100 beds….and a waiting list of 300.

Although anti-psychotics have had a major effect on reducing the need for hospital beds since the 1950s, the rise of street drugs, combined with the vulnerability of the mentally ill, has worked in the opposite direction.

Anecdotes tell the story, too. When someone in the depths of psychosis is certified but has to wait two or three days in Emergency because there is no room in acute care, we know something is wrong.

## *Needs of most seriously ill not adequately understood*

Where was the mistake made?

You could say it began with the notion that treatment and care in the community was automatically better than in a hospital facility, especially an old and physically decaying facility like Riverview.

NSSS always took this slighting of Riverview in the name of "treatment in the community" with a grain of salt. Aren't hospitals part of the community? Riverview, too, could no longer be described as being in the boondocks. Coquitlam is now central to much of the Lower Mainland.

NSSS, while wanting a newer and smaller psychiatric facility at Riverview, for longer-term patients,

and also wanting to preserve and take advantage of the Riverview lands and its heritage arboretum, didn't object to treatment in the community, with the proviso that adequate care and treatment be provided.

This didn't happen because community mental health services simply weren't up to the task. Riverview provided housing, of course, but also structure and continuing medication. In "the community," on the other hand, if someone stopped taking their medication and didn't show up for an appointment, as often as not they were left to languish. Community Psychiatric Services (CPS) on the North Shore simply closes the file.

Then there was the acute-care logjam and much ignorance – often obdurate ignorance - among service providers about the provision in B.C. for involuntary admission.

The leading criterion for involuntary admission, as readers of the *Bulletin* know, is "to prevent substantial mental or physical deterioration." This isn't just a clause in the Mental Health Act. It's also a proxy for a standard of care.

This has hardly mattered in practice, however. As one case worker put it, blithely dismissing the provision, "If we used that criterion, we would have to certify half the population of the Downtown Eastside."

One of the better alternatives to longer-term hospitalization is Assertive Community Treatment (ACT), an around-the-clock team approach once described as a "hospital without walls." Health authorities in the province, however, have been blind to the need. Only very belatedly have they created an ACT team or two (Vancouver Coastal having established its first ACT team just this year).

ACT, moreover, with its own limitation in resources, isn't the whole answer, either.

Reflecting on the downsizing and closure of Riverview, we're reminded of an NSSS-sponsored panel on the subject, in 2007. A mother in the audience spoke up. She wasn't impressed by all the genuflecting to treatment in the community.

Her son, ill with schizophrenia, was in Edmonton, on the street, badly addicted and disoriented and, as she saw it, killing himself in the community. What was wrong with a place like Riverview, she asked, where he would be safe and have much more of a life? He would be much better there.

The comment, so forthright and politically incorrect, cut across the chatter and stilled the crowd.

What could one say?

# *Schoenborn case a street of sorrows*

It was tragic enough that somebody in the throes of paranoid psychosis killed his three children, to put them where they were safe, as he imagined it.

It's doubly tragic there were so many failures by social workers in adequately assessing the risk of his untreated mental illness and protecting against it, although they were heavily involved in the case.

The details have now been made public in a report by Mary Ellen Turpel-Lafond, the Representative for Children and Youth in B.C., released in March.

The case revolves around Allan Schoenborn, the father of the three children, who is now in B.C.'s Forensic Hospital, having been found not criminally responsible because of a mental disorder.

Schoenborn, who suffered from alcohol abuse as well as mental illness, was well-known to both the Ministry of Children and Family Development (MCFD) and the police. Turpel-Lafond's report takes us through an amazing, convoluted history of MCFD and police interventions, incidents of domestic violence, seemingly countless investigations, orders and withdrawals of orders, arrests and court appearances, and other twists and turns.

In the week leading up to the children's death in 2008, no fewer than 14 professionals were involved with the family.

Despite all of the system's efforts, the worst happened.

A lot of faulty practices and omissions contributed. The primary cause, however, as the report suggests, was that "most of the social workers involved in working with this family lacked an understanding of the nature and extent of the father's mental illness."

It's to Turpel-Lafond's credit that she recognizes this and the parallel failure of MCFD to consult and work closely with mental health services.

She also discusses Schoenborn's difficulties and goes into the provisions in the Mental Health Act for involuntary admission and treatment.

Her report, however, unfortunately doesn't explore how the culture of mental health services may have discouraged a more pro-active approach to getting Schoenborn into hospital.

Not all of the social workers failed to understand how ill Schoenborn was. In August 2007, seven and a half months before Schoenborn killed his children, an MCFD social worker updated the comprehensive risk assessment to "high risk."

It would be interesting to find out why he or she didn't call on mental health services– interesting as well to find out why the police, who were also involved, didn't use the "likely to endanger clause" in Section 28, their authority under the Mental Health Act, to take Schoenborn to hospital for an assessment

He had previously been involuntarily admitted to hospital, in 1999, but because a general practitioner, approached for the requisite second certificate considered he couldn't be committed, he was prematurely discharged. (The signer of the first certificate, a psychiatrist, had diagnosed him as delusional and paranoid.) There was no follow-up.

His wife, hoping he would be kept in hospital until he was adequately stabilized, felt helpless. She didn't know where to turn.

There's also a hidden irony in Turpel-Lafond's approach. As a representative of the children, she sees everything through the lens of how the lack of appreciation of Schoenborn's mental illness put the children at risk. That's her job.

What about Schoenborn himself, though? He was ill and needed treatment – requiring in his case involuntary admission – to get better. He should have got that help.

Nobody who was involved seems to have addressed that. Had they done so, focusing at least a little bit on Schoenborn's illness for his sake, rather than being caught up so completely in the often arcane complexities of child protection and the justice system, they might have knocked on mental health services' door and got him the help he needed after all.

One more irony, and one more cause for regret.