NSSS ADVOCACY BULLETIN
Vol. 5, No. 1 September 2012

Ill people left unhelped confounds police officers

When a crisis hits, many families, desperate to get help for their mentally ill loved one, have no choice but to call police. It's all the more important, then, that police concerns be taken into account by mental health services.

Even when there's a formal liaison arrangement for the two parties to talk to each other, however, it doesn't always happen.

The root of the problem lies deep in the heart of the culture of mental health services.

The leading difficulty is that many quite ill people are not kept in hospital to be treated, something that baffles police officers who have brought them to hospital for an assessment because they were "likely to endanger that person's own safety or the safety of others."

There is a crisis of some sort in such cases – frightening suicidal ideation, wild behaviour, assault or threats, or illness so severe it's impossible to predict what might happen.

Keep in mind, too, that families aren't usually going to call the police for help unless they're desperate or their loved one's talk of suicide or other threats can no longer be rationalized away.

If anything, families are going to delay calling the police until they realize there's no alternative, especially if it's a first break and they're still trying to understand what is happening.

Police become a bit cynical about hospital routine

Officers then arrive, responding to the call. They talk to the ill person and the family members. They take notes. They may have been briefed ahead of time. They apprehend the person and take them to hospital where the officer may have to wait for hours until a psychiatrist or other physician takes over.

The next thing they know, in many cases, is that the person isn't kept in hospital at all.

It's not surprising, then, the police have become a little bit cynical about the routine.

A whole folklore has developed around it.

Internally the police jokingly call it the "catch and release" program, all the while knowing the plight of the mentally ill is not a joking matter.

One North Vancouver RCMP officer reported that while he was typing out his report on one such apprehension, he looked out the window and saw the person he had just taken in for help walking out of the Emergency entrance instead. (Emergency at Lions Gate Hospital is just across the street from the RCMP.)

The least the hospital could do, he commented wryly, was to have the person leave through another exit where the officer, finishing his report, wouldn't see him depart.

Another officer, in the Sea to Sky corridor, reported the assessment was so hurried and the decision not to certify made so quickly, he ended up driving the ill person home himself.

Inappropriate decisions can lead to tragedy

One could take this all philosophically if it didn't mean people who needed treatment were left prey to their illness and that, sometimes, greater tragedy followed.

The relevant clauses in the Mental Health Act giving police officers the authority to take someone to hospital if they're "like to endanger…" are in Section 28. A senior North Vancouver RCMP officer recalls a Section 28 case in which the woman brought to Lions Gate wasn't certified and hanged herself the next day.

In the Mohamed Amer case in Vancouver earlier this year, the ill man was brought to St. Paul's by the Vancouver police, but not certified, and then brought back by police the same day, and again not certified. The next day he walked into a coffee shop and stabbed a complete stranger twice in the chest.

The Amer case has been the subject of an inquiry undertaken by Providence Health and Vancouver Coastal Health.

Disconnect between system and what police observe

Why do so many instances of the police bringing someone to hospital under Section 28 not result in involuntary admission and treatment?

The police don't have psychiatric training, and it's not their job to do a psychiatric assessment in any case. That part of the process rightly belongs to psychiatrists or other physicians.

Police officers, though, do have experience with the mentally ill and are able to make common-sense judgements about risk to safety, leading to apprehension under the Act.

Moreover, protection of the person or others, for which the police take someone to hospital, is also a criterion of involuntary admission. One would expect, then, a fairly close correlation of the two steps.

A psychiatrist doing an assessment need not even be convinced of a risk to safety (the relatively narrow police criterion for acting). The psychiatrist can, and should, keep someone in hospital if necessary to "prevent substantial mental or physical deterioration," the leading criterion for involuntary admission in B.C.

This is a broader provision than the one the police work under. All the more reason, then, to expect involuntary admission where the police have had to bring someone to hospital.

In NSSS's experience, the disconnect between the two, when it occurs, is almost always because of inadequacy on the hospital's side – the physician not giving sufficient weight to collateral information from police or families, not giving the assessment sufficient time and care, a failure to understand the actual provision for involuntary admission in the Mental

Health Act, or having the decision negatively influenced by too much pressure on acute care beds.

Something's got to change.

Key possibility for improving system yet to be taken up

There is a lot of hair pulling about shortcomings in mental health services, including pointed criticism by many people working in the system itself, yet a key possibility for improvement hasn't been considered.

That key missing element is training sessions for professionals by representatives of family advocacy organizations like NSSS.

It almost sounds counter-intuitive… until you think about it. After all, professionals are "professional" and are supposed to be fully trained. Such at least is the assumption that goes with their degrees, job titles, and status.

Family members, on the other hand, are lay people, so what can they and their organizations possibly contribute to the training of already trained professionals?

Reality, though, is quite a bit different. Professionals often don't even know some of the basics, like their own mental health act's provision for involuntary admission or the provision in privacy legislation for sharing information with family members.

NSSS, by contrast, knows all about those provisions because they're crucial in helping family members get treatment for their loved ones and to their participating as full-fledged members of the treatment team.

Experience and necessity, in representing family members, has driven us at NSSS to become experts on those questions.

Our support workers are often in the position of having to explain to professionals exactly what the legislation says and what the implications are for the way they function and make decisions.

Family members would also bring their independence to the training of professionals, and with it an insight and understanding that currently is absent.

System failures and baffling, harmful, sometimes outright incompetent clinical decisions happen all too often. The *NSSS Advocacy Bulletin* covers these failures regularly. Our March 2012 issue gave special attention to them with case history after case history illustrating the most egregious, unacceptable kind of practices.

There's a lot to learn from these case histories, but it's not learned now, because without family members represented on teaching staffs, that particular understanding of what's counter-productive and what makes sense isn't there.

Questionable practices and system failures, as a result, just keep repeating themselves, and people with the most serious mental illnesses pay the price.

There is also, for professionals, no training of any substance on working with family members as part of the treatment team, although family involvement is part of best practices and an important factor in producing the best possible outcomes.

It's another telling omission, and a gap that can only be properly filled by family members themselves instructing psychiatrists, psychiatric nurses, and case workers, on their experiences and what's required.

The National Alliance on Mental Illness (NAMI) in the U.S. has developed a five-module program for service providers on the experience of mental illness, with family members and those with an illness involved. NSSS has in hand a custom-made program for those doing their psychiatric residency at UBC and a parallel program for service providers, based on NSSS's extensive support and advocacy work and its archive of case histories.

These are at least a beginning. The existence of such programs in itself doesn't mean much, however, if mental-health service providers and university psychiatry departments aren't open to them.

It remains to be seen whether they'll have the insight necessary to break out of their silos and realize how crucial such training is.

Family role in system oversight also goes missing

Training isn't the only area where families' unique experience and knowledge go begging.

They're also missing from system oversight.

One of the consequences: There's no accountability in the system, and inappropriate practices and behaviour, and sometimes disastrous decisions, continue unimpeded without any check or corrective instruction

So-called "quality improvement committees" that currently look into complaints often, in NSSS's experience, just whitewash what has happened or stonewall, especially if a senior psychiatrist is involved.

This means little consistent improvement takes place. Since there is no open acknowledgement of someone having mishandled a situation, no lessons can be learned.

Those who currently sit on quality improvement committees are loath in any case to be critical of their colleagues, which often means they are not going to get at the root of anything that was done improperly.

A representative of family members on these committees would help change things in a positive direction.

They would bring to the table an independence in feedback and oversight necessary for the gradual improvement of practices.

Family members' absence from such committees is a hangover from previous times, before the value of family involvement in the treatment process was recognized.

If, however, family members are to be an integral part of the treatment team along with psychiatrists, nurses and case workers, as they should be, then they should also be represented on quality improvement committees just like those other groups.

You can expect cries of protest and stubborn opposition from those other groups at the very idea, just as many originally protested the idea of family involvement to begin with, despite its benefits for the mentally ill.

These protests will only confirm why family representation on quality improvement committees makes so much sense.

FEEDBACK WELCOME

We welcome your comments on any of the issues covered in the *NSSS Advocacy Bulletin*. Please call us at 604-926-0856 or send us an email at advocacy@northshoreschizophrenia.org.