NSSS ADVOCACY BULLETIN
Vol. 5, No. 4 March 2013

Anatomy of a successful response to a crisis

It is one of numerous cases the NSSS Family Support Centre handles every year, and an illustration of the system working properly despite a crucial disadvantage. Some details have been altered.

A young man with schizo-affective disorder was decompensating. He had stopped taking his medication and it was beginning to show. He was openly paranoid, convinced that evil forces were conspiring to get him. Other delusions had become apparent, and his agitation was increasing. He told a friend with whom he went on an outing that he was thinking of jumping from a bridge into deep water.

Mind you, he hadn't hit anyone. He hadn't burned down the family home. He hadn't attempted suicide…well, at least not yet. He hadn't committed a crime. He had no history of violence. He was, though, quite ill and needed help badly.

His parents, who loved him dearly, had been keeping a careful eye on him, knowing what might happen without medication. Unfortunately their son wasn't willing to go to hospital on his own. Sizing up what was developing, they called the NSSS support coordinator to explore possible strategies.

They subsequently met her at the Centre, together with a second member of the Support Team, to talk over what might be done.

The first option was to set up an appointment with the son's former psychiatrist at the community mental health team, who knew his history. Instead of going to the appointment, however, the son took off. The situation became even more urgent, although he was located the next day.

The parents called the NSSS support coordinator again to confer.

They went over the possibilities. One was to get the boy's general practitioner to sign a first certificate for involuntary admission to hospital, which would give police authority to escort him to hospital.

At the parents' request, the community mental health psychiatrist briefed the GP on the son's history. He would need to see the young man, however, which couldn't happen until the following day, and even then there had to be some way of getting him to visit the GP to begin with.

Another alternative was to get the police involved directly, using Section 28 of the Mental Health Act – the provision that allows them to take a person to hospital for an assessment if the person is acting in a manner "likely to endanger" themselves or others.

Calling the police is never something one likes doing, but there was another consideration: Could one be assured nothing tragic would happen overnight? It was a judgement call. The NSSS support worker didn't want to take that chance and the parents agreed.

West Vancouver officers act with skill and finesse

The police were called and conferred with the parents ahead of time. At the support coordinator's suggestion, the mother had put together a summary list of their son's deteriorating behaviour. Going through the list and listening to the parents, the officers concluded they had no choice but to take the son to hospital under Section 28. They handled the subsequent encounter with the ill young man with skill and finesse, talking to him first and then taking him willingly in their squad car to Lions Gate Emergency.

The emergency physician at Lions Gate, for his part, after interviewing the young man, came out and talked to the parents, who had also gone to the hospital. The doctor also read the notes they gave him.

The young man was duly certified and moved to acute care for observation and treatment.

The parents could hardly believe things went so smoothly. "It went like clockwork," the father reported. Their son was safe!

Seriously ill young man kept safe and given help

Several things were done right.

The community mental health psychiatrist, who had previously treated the son, shared the relevant information he had and his own observations with the GP. The GP understood he could sign the first certificate and also that, in order to do so, he would have to see the patient first – within the previous 14 days as required by law.

The police officers gave proper weight to the observations and notes of the parents and the prior history they related, basing their decision on that information.

They also didn't insist the young man had to be overtly dangerous right in front of their eyes the very moment when they intervened.

In so doing, they recognized what Section 28 actually says: first, that the person doesn't have to be dangerous but "likely to endanger," which allows them to take into account circumstances, and second, that they can act on "information received from others" rather than having to rely entirely on their own observations.

The physician at the hospital didn't limit himself to interviewing the patient, which would have risked his being misled by the ability of a seriously ill person, in an official setting, being able to present well for at least a few minutes.

He also talked to the parents and integrated their observations and the details in their notes into his own assessment.

The end result: a seriously ill young man, deteriorating, was kept safe and given the help he needed.

Everyone involved could be congratulated for their professionalism.

Lack of urgent outreach a continuing deficiency

We would like to call this a "textbook case" of things going well, but we can't, because one crucial element was missing.

Unlike Vancouver and Surrey, or Nanaimo for that matter, the North Shore has no urgent outreach team that could have gone to the young man's home to assess him there.

The parents should not have had to even consider getting the police to use Section 28. Nor should they have had to think of having their GP sign a first certificate.

They should have been able to call an urgent outreach team instead. Ideally this team would include a psychiatrist who could sign a first certificate on the spot, rather than having to be brought in later.

The psychiatrist could also take a broader approach than police officers, looking first at whether the person was substantially deteriorating.

Ultimately, dealing with the illness – dealing with the deterioration – is the only way to keep a person genuinely safe and to get them well.

Parents given education and the confidence to act

On the surface, that's the story. Below the surface, however, is another story even more critical than the actions of the police officers and hospital emergency – the role of the parents and of the NSSS Family Support Centre and its support coordinator.

The pro-active engagement of the parents didn't just happen out of the blue but was part of a complex process with, at its core, the Family Support Centre itself.

Both parents had taken the Centre's education course Family-to-Family, where they would have come to grips with what serious mental illness involved, among other things preparing them to watch out for signs of relapse and to take action when they cropped up.

They would have learned, in Class 2 of the 12-session course, the details of police intervention. They would have also learned, from the co-teachers, what it was actually like to call the police.

The co-teachers would be family members with an ill loved one themselves and likely able to speak from first-hand experience about police intervention – talk about the conflicting emotions at play but how, nevertheless, asking for police help in such emergency situations was the most loving thing family members could do.

This would have prepared the parents emotionally for following through when they had to.

They would also, from the course, and from hearing the stories of other family members, gain confidence in themselves in advocating for their son and taking action.

NSSS peer experience provides crucial insight

They were able, as well, to call on the NSSS support coordinator to talk things through, explore possible strategies, help make decisions, and be briefed on details. As the father later put it, "It sure helps to know the ins and outs."

NSSS wasn't just a telephone number of an agency they might call up to speak to somebody. It was an organization of their peers with which they had a profound connection of shared experience.

It was also an organization that for 30 years had approached situations like the one they were in exactly from their vantage point and that could bring the experience of countless case histories to bear.

This would be particularly relevant when it came to deciding how quickly they should act. NSSS has long experience of service providers failing to act quickly or pro-actively enough and of untenable excuses for doing so – "He has to be dangerous," "He has to come in himself" – that might suit the circumstances of mental health services but not what the family members know is clinically needed and is envisioned in the Mental Health Act.

Let's focus on the one most crucial moment in the story, with the parents and support coordinator discussing whether to call on the police that evening, with the uncertainty and tension that goes with it, or wait until the next day and try getting the son to the GP.

NSSS experience dictated that with someone as paranoid and agitated as the young man was at that moment, it was better not to delay.

There were just too many previous cases the support coordinator knew of where delay, even a delay overnight, had resulted in dire consequences.

Parents and peer support played most important role

NSSS may have contributed in other, indirect ways. It conducts workshops for the West Vancouver Police Department and the RCMP in North Vancouver and the Sea to Sky on Section 28, underscoring that officers can act on information received from others – which is what they did in this case.

Recently NSSS provided panelists (family members and those with an illness) for presentations to a training program for West Vancouver police officers on handling crisis situations involving the mentally ill.

NSSS has also been in the forefront in advocating for the sharing of information with family members and of including them as integral members of the treatment team.

Note that it was the parents in this case who were the *de facto* therapists for their son, trying to keep him engaged and safe. It was they who watched for signs of relapse after he stopped taking his medication. It was they who initiated the sequence of events that got him into hospital and the clinical help he needed. It was they who put together a summary of his symptoms, in effect a diagnostic platform, without which the police officers and the hospital would have been at a disadvantage. It was they, too, who absorbed the stress of dealing with an increasingly serious situation.

Even in this case, then, where the system responded seamlessly and well, it was the family members, with the help of the Family Support Centre and its programs, who played the most important role.

As of press time, the rest of the story is yet to come – whether the ill young man will be kept in acute care until he's adequately stabilized; whether extended leave is used when he's discharged so that his medication can be maintained and supervised, and whether clinical information is freely shared with the parents.

So far, though, so good, We can only hope, too, that in the not too distant future, the North Shore will have urgent outreach as well.