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Primary training needs to catch up on info sharing

First, a bit of background…

B.C.s Freedom of Information and Protection of Privacy Act (FIPPA), enacted in 1996, recognized that in cases of severe mental illness, where a patient might lack insight into what was happening and also be paranoid and delusional, allowance should be made to share clinical information with third parties, like family members, even without the patient's permission,

Later on, the Ministry of Health issued a fact sheet explaining, among other things, the application of FIPPA to cases of mental illness.

The Ministry of Health took the relevant wording of the Act and put it into practical context. Such information sharing could take place without the consent of the client, the Ministry's bulletin read, "where disclosure is required for continuity of care or for compelling reasons if someone's health or safety is at risk."

Unfortunately, professionals and mental health service managers, with a few exceptions, failed to respond. They continued to claim, incorrectly, that "rules of confidentiality" prevented them from sharing information with family members.

For a comprehensive analysis of the issue, please see the November 2010 *Bulletin* at www.northshoreschizophrenia. org/bulletin.htm.

New policy elaborates on information sharing

Flash forward, now, to 2013.

Vancouver Coastal Health, albeit almost two decades after FIPPA was enacted, has finally tackled the question in a meaningful way, in a policy memorandum, "Family Involvement in Mental Health & Addiction Services."

A questions and answers supplement, outlining how information sharing could take place, explains that even in the absence of consent, service providers "may share with family members who are within the circle of care information they need to provide care."

Although the new policy still doesn't follow through adequately on some aspects of the issue, it represented a considerable initiative for the better. A workshop on the policy has been held and a training presentation developed.

It looks as if information sharing with family members and others who might be involved in helping someone who was mentally ill is about to properly take place.

Nurses training not in sync with best practices in field

What will happen, however, if the qualifying training of mental health professionals – the training of psychiatry residents (doctors), psychiatric nurses and social workers, doesn't move forward in the same way?

Psychiatric nurses in training at Douglas College, for example, are reportedly being instructed that under no circumstances should they share information with others, like family members, without the patient's permission.

Imagine then, to cite a recent instance, a young psychiatric nurse, recently graduated from Douglas College, being told at a hospital workshop on family involvement that, under the law, she can indeed share clinical information with family members. She can do so even without the patient's permission, when continuity of care is involved, as it always is where families are on the scene.

It's the first time the nurse has heard of the notion. For her, it sounds like heresy, and although the background on information sharing is given to her, the idea is still something she has difficulty absorbing.

While allowing that what she has just been told may be correct, she confesses she is going to have great difficulty being open in the way the workshop has indicated. "It was drilled into our heads every day that we shouldn't share information with anyone," she explains.

A glimpse at a standard nursing textbook, a heavyweight tome entitled *Canadian Fundamentals of Nursing*, widely used in B.C., throws further light on how nursing students are misled on the issue.

It says, point blank, "the nurse should not disclose the patient's confidential medical information without the patient's consent." There is no qualification for cases of serious mental illness or any reference to FIPPA or the Ministry of Health fact sheet with its case-history illustrations, for those nurses working in B.C.

Instead, perversely it effectively warns nurses not to share information with family members exactly in cases of mental illness: "A nurse should not assume that a patient's spouse or family members know all of the patient's history, particularly with regard to private issues such as mental illness, medications…," as if someone in one's family becoming psychotic were a "private issue".

It does allow that confidentiality isn't an absolute value, but the exceptions it mentions, such as child abuse or gunshot wounds, don't include severe mental illness. (Mind you, for British Columbia, this seemingly authoritative textbook also gets the criteria for involuntary admission wrong.)

Question raised about others in mental health

This problem with nurses' training raises the question in turn of whether psychiatrists, social workers, and general practitioners are also inadequately trained about information sharing – or worse indoctrinated with the wrong idea.

Those in mental health services leading the way on information sharing may have a greater challenge than they imagined.

Provincial judges could also benefit by more instruction

Provincial judges are another group that could do with better training on questions relating to the mentally ill, particularly when it comes to issuing a warrant to have someone taken to hospital when they are ill but won't go on their own.

Applications to a judge for a warrant are growing more common, especially in areas like the North Shore and the Sea to Sky where mental health services doesn't provide urgent outreach.

A concerned family member can call the police to intervene, but the criterion for the police to escort someone to hospital (Section 28 in the Mental Health Act) is relatively narrow – "likely to endanger" – notwithstanding the person may be quite ill and in need of treatment.

An urgent outreach team can bring in a psychiatrist or other physician who, seeing how ill the person is, can sign a first certificate using the broader and more realistic criteria of Section 22: (a) to prevent substantial mental or physical deterioration or (b) for the protection of the person or others.

What, though, if there is no urgent outreach?

Criteria for issuing warrant same as for certification

Here is where an application to a judge comes in. The criteria for a judge, in considering a warrant in these urgent situations, are exactly the same as the criteria for a physician to sign a first certificate. Someone who is quite ill and deteriorating can consequently, via a warrant, be taken to hospital for an assessment.

A justice of the peace, in rural areas where a judge isn't available, can also issue the warrant.

So far, so good. Helping to get ill people to hospital for an assessment, when they have no insight into their illness, is the reason why the provision for a judge's warrant was put into the Act to begin with.

Some judges, in our experience, have a good understanding of this rationale and even a wider understanding of what happens when ill people aren't treated. They see plenty of mentally ill in their courts facing charges who, they sense, really shouldn't have to be dragged through the justice system, not to mention taking up court time..

They hear, like the rest of us, how the police have had to become default front-line mental-health outreach workers, in urgent cases and, too often, chronic cases; about the shortage of acute care beds; of how untreated mental illness can lead to substance abuse and degradation.

They listen carefully, too, to the family member appearing before them in court to speak to their application, knowing that it takes courage and often despair for them to get that far. And if, based on the applicant's testimony, the judge finds there are "reasonable grounds" to conclude the person in question is ill and deteriorating, they issue a warrant.

Many judges understand, but others have difficulty

In one case involving a mother and NSSS member, the judge, in handing down the warrant, wryly wished her good luck. Both judge and mother understood, together, the subtext:

"Your daughter is quite ill. She should be in treatment and kept in hospital long enough to get her truly stabilized. Given what happens, though, you might not even get a second certificate. Here is the warrant nevertheless. Your daughter qualifies and needs help".

These judges understand the meaning of Section 28 (3) and (4) of the Mental Health Act – the enabling section for a warrant – and understand their duty under it.

Then there are the others.

They start with the premise that issuing a warrant is a terribly serious matter, mandating the arrest of an individual and depriving them of their liberty. They may even condescendingly lecture the applicant about it.

We can all concede a court order of any kind is serious business, but so is mental illness. The rhetoric of depriving someone of their liberty, meanwhile, as if they were to be thrown into a dungeon on some penal island, is a red herring.

The warrant provides for a person to be kept in hospital for up to only 48 hours and that for the purpose of assessment. Receiving treatment for an illness, moreover, isn't punishment but help.

The next step after the warrant and escort to hospital is, in any case, not for the judge to decide but for the psychiatrist at the hospital.

Occasionally a judge might use dangerousness as a criterion for issuing a warrant, so that even if someone is delusional and deteriorating, but not openly dangerous, the request for a warrant will be denied.

One judge who seemed to operate that way was questioned about it at a public forum. What was the requirement for a warrant, he was asked.

He opined that "Perhaps if the ill person was going to harm someone…"

Clearly, "dangerousness" was the standard he was invoking.

This is mistaken. The requirement for issuing a warrant isn't dangerousness at all, but the criteria used for involuntary admission: (a) to prevent substantial mental deterioration, or (b) to protect the person from harm.

Questioned further on the matter, the judge wouldn't be pinned down, rattling on instead about affidavits and evidence, quite off-target.

It appeared he didn't really know what the requirement actually was.

It's not the first time NSSS has run into supposed authorities who don't know the basics.

Family member's account can stand on its own merits

A judge might also express concern about having to act on the applicant's word, without third-party clinical back-up. This makes sense when the details presented are too hazy – when, in effect, a case hasn't properly been made. Otherwise, though, it too is a red herring. The person applying for the warrant, say a mother, will likely have been the one person – the only person – who had been carefully and systematically observing her loved one's symptomatic behaviour and will probably, also, have kept careful records.

Whether the issue has to do with information sharing or judicial warrants, the lack of knowledge of basic particulars isn't a minor matter.

It can have serious and sometimes tragic consequences.

Somehow, whether in original training or in later professional development courses, these gaps in education need to be systematically addressed.