NSSS ADVOCACY BULLETIN
Vol. 7, No. 2 November 2014

# *More problematic case histories, for the record*

Despite a workshop on the Mental Health Act for Vancouver Coastal's mental health services staff, the incorrect criterion for involuntary admission, dangerousness, is still used too often in practice.

Dangerousness, of course, is not required for involuntary admission – indeed, isn't even specifically mentioned in the relevant section of the Act. "To prevent… substantial mental or physical deterioration" is the leading criterion for certification.

One still, however, hears mental health workers explain, for example, that they can't intervene with someone, although the person is very ill, but "if he's suicidal," well then they could do something.

Or, in rationalizing a premature discharge, "Well, he's not going to murder anybody."

Or for someone who is clearly delusional, "He's not there yet," – 'there" serving as a euphemism for being so utterly crazy that he will be dangerous.

In one instance, an openly psychotic woman virtually made a clinical case for admission on her own by circulating a leaflet which revealed her fantastic paranoid delusions in detail. The leaflet, needless to say, was meant to get the powers that be to take action – to ward off the dark, wicked, technically ingenious forces out to get her.

Staff at a senior citizens centre which she frequented grew alarmed at her deteriorating condition, but couldn't get anyone in the system to pay attention. Nor could the woman's son.

NSSS, when contacted, did take up the case and pointed out to Mental Health Services the need for involuntary admission, given her lack of insight and entrenched paranoia.

The mental health manager, in response, offered, "Well, if she's not actually hurting herself…" again apparently using a physical dangerousness standard.

The woman was obviously ill, however, and NSSS was persistent, so Mental Health Services didn't feel free to close her file. Instead, in a Keystone Kops kind of exercise, the file ended up being moved back and forth between different programs, presumably with the hope that, at some point, someone would actually follow through. As of press time, the ill woman still hadn't been hospitalized.

It's hard to conceive this happening if service providers properly understood the provision for involuntary admission in the Mental Health Act.

## *NSSS families provide training and mentoring*

The workshop on the Act was provided for Vancouver Coastal mental health staff in the spring of 2011. It was the result of a campaign by NSSS following a suicide case where mental health services in Vancouver failed to use involuntary admission although it was clearly called for.

The concern that such a workshop was needed for something so fundamental – something service providers should have learned about at the beginning of their training – wasn't lost on the Society.

Nor did NSSS have any illusions that a single workshop would in itself dramatically change the way mental health workers responded to cases in the real world.

The workshop would help but still wouldn't carry them far. What is required is continuous training and mentoring, with case illustrations, led by families determined to keep on top of things and to move practices forward.

Families can be part of the solution in an otherwise overloaded healthcare system.

## *The case for family education and support*

Other factors can intrude, like the shortage of acute care beds, but that shouldn't be allowed to get in the way of sound clinical judgment.

Take the following case at St. Paul's Hospital just this last spring.

Like many psychiatry wards in Canada and the U.S., St. Paul's just doesn't have enough acute care beds. Many patients end up in emergency for days, the Emergency Ward effectively becoming an offshoot psychiatry ward, not at all a good situation.

Enter a woman concerned about her very ill, psychotic brother who has been sick for years, but keeps falling through the cracks. He won't go to hospital himself, nor can she get him to see a GP who might sign a first certificate.

Desperate, she finds a GP willing to go out to her brother's place instead. The GP, seeing how ill he is and with the sister's collateral information, signs a certificate, and he is taken to St. Paul's.

The intake psychiatrist, however, after talking to the GP, decides that he doesn't qualify for involuntary admission.

"But he's so ill," the sister says, speaking to the psychiatrist on the phone. She refers to the considerable file, including a previous psychiatric assessment, which had accompanied her brother..

"You should see the people we see here," the psychiatrist explains. The brother, on the other hand, has had a haircut and looks presentable.

The explanation doesn't satisfy the sister. She says she'll come to the hospital if necessary to discuss exactly why he won't be admitted. She has the Mental Health Act in hand.

"He's not suicidal," the psychiatrist tries again.

The sister points out some past suicidal ideation.

"He seems to be keeping himself alive," the psychiatrist offers.

"If I stopped bringing him groceries he would starve and be out on the street."

"Maybe that's what you need to do [to get him admitted]," the psychiatrist muses.

"I'm not going to let him starve!" the sister exclaims.

Finally, the psychiatrist, hearing the desperation in the sister's voice, says "I'll give him 24 hours but I can't guarantee the psychiatrist who sees him next will keep him after that."

The shock of being in the psychiatric ward is such, however, that psychotic symptoms manifest them-selves openly, and they do keep him.

The sister also gets involved later to forestall a premature discharge, especially given that, at that point, he has no place to go.

All in all, the brother is at St. Paul's for two months.

Three things in particular come to mind, looking back on the case.

First, St. Paul's, notwithstanding their initial resistance, deserves credit for in fact admitting him despite their patient overload and the pressures that come with it.

Second, they might not have done so at all if his sister hadn't been on hand to advocate for his treatment.

And third: there never should have been any question at St. Paul's about his being admitted, given how ill he was. The reference to the brother's not being suicidal was a red herring, as we know from what the Mental Health Act actually says.

Educating families to hold the line continues to be a critical role for NSSS.

# *Iacobucci report raises questions about police incidents*

Fatal police shootings of those with a mental illness are becoming a growing concern, with inquest jury verdicts and major studies coming out with long lists of recommendations.

Most of the recommendations are for better training, the need to de-escalate crises rather than bark out command orders, more officers equipped with Tasers, the use of body cameras to record incidents and provide better accountability, and so on.

All these are worthwhile, but somehow they don't get at what lies underneath the surface in fatal incidents: Police officers, while protecting themselves from risk even if the risk may have low probability, shoot someone who is mentally disordered, where the probability of grievous bodily harm or death is 100 per cent

A report by former Supreme Court Judge Frank Iacobucci in Toronto, however, prompted by the fatal shooting of Sammy Yatim (see the Advocacy Bulletin's September 2013 issue), does at least acknowledge the dilemma.

The report, *Police Encounters with People in Crisis*, makes the usual motherhood recommendations: minimize the use of lethal force wherever possible, increase the emphasis on the seriousness of the decision to use lethal force, and further emphasize lethal force as a last resort.

It then goes on, however, to point to the need to "articulate the importance of preserving the lives of subjects as well as officers whenever possible."

This is a different recommendation in kind because, at least in language, it puts the same value on the lives of those who are ill as on the lives of officers themselves.

Not that such a recommendation lends itself to obvious remedies in practice, but it does shift the context of understanding.

## *De-escalation training key to preserving lives*

Another interesting aspect of the report is its discussion of the Metropolitan Police Service in London, England, where most officers are unarmed.

The Met, as it's known, does have armed units (about 10 per cent of the force are issued firearms). When conducted energy weapons (CEWs) like Tasers were first introduced, they were similarly issued only to special units (less than 10 per cent of officers). By contrast, first responders are equipped with only batons and pepper spray and rely more on verbal communication than weapons to resolve crisis situations when there is insufficient time for an armed unit to attend the scene.

Even more interesting, the Metropolitan Police Service has formed a separate group that responds to incidents involving "edged weapons" like knives. This group also doesn't have firearms, but is equipped with shields and CEWs. Their training includes techniques for de-escalation and also how to overpower an armed subject without resort to a firearm or other weapon.

Unless there is risk to a broader public, police with firearms are typically not deployed in situations involved edged weapons.

Young Sammy Yatim in Toronto was holding a knife, that is, an edged weapon (the officer who shot him has been charged). Here in B.C., Greg Matters in Prince George was allegedly holding a small hatchet. Michael Vann Hubbard, a homeless man, ill and paranoid, had in his paranoia pulled out an X-Acto knife when he was gunned down. Brian David Shaw had a probably blunt-ended table knife. Paul Boyd had only a bicycle chain.

If they had been living in London, England, they would likely all be alive today.

"There is no reason to believe that London has fewer people in crisis than Toronto, or that people in crisis in London are less dangerous than in Toronto," the report explains, "yet police in London are involved in substantially fewer [per capita] lethal shootings of people in crisis than the Toronto Police Service."

*FEEDBACK WELCOME*

*We welcome your comments.*

*If, also, you have a story of your own about struggles with the system or short-comings that need to be remedied, and would like to tell us about it, please email us at advocacy@northshoreschizophrenia.org, call 604-926-0856, or drop by the Family Support Centre, 205-1856 Marine Dr., West Vancouver, B.C.*