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Sometimes things don't change to begin with

In mental health services on the North Shore and Sea to Sky, it's not always "the more things change, the more they remain the same." Sometimes it's just things not changing to begin with.

Basic lapses continue, despite efforts to bring problems to light and even system-wide seminars to deal with them.

Take, for example, an intake worker telling NSSS, in the case of someone quite delusional, that this is Canada, we can't just go around picking up people and putting them in hospital, if they're not dangerous.

Well, we all know this is Canada, and British Columbia, and in B.C., if someone is ill but doesn't have insight, we're supposed to help them, not evade the issue with cant.

The Mental Health Act, moreover, as the *Bulletin* repeatedly points out, specifically allows for involuntary admission in such situations: "to prevent the person's substantial mental or physical deterioration."

It's not respecting a person's liberties, either, to leave them a prisoner of their psychosis. (For more on this, see www.northshoreschizophrenia.org/ Uncivil_ Liberties.)

The irony is that this very matter of involuntary admission was the subject of special day-long seminars for Vancouver Coastal mental health staff, following the notorious system failure in the Mark Kwapiszewski case, in 2007-2008. (See the *Bulletin's* September 2009 issue on the NSSS website and the documents on the case available through the site's Media Centre page.)

We noted that immediately after the seminars, in the spring of 2011, the old misunderstanding about involuntary admission was still being repeated, as if the seminars, by health law expert Gerrit Clements, had not been given.

Nothing much seems to have changed in the interim.

Nor is simply knowing what the law says sufficient either.

There was the case of an intake worker with Mental Health Emergency Services in Vancouver, whom NSSS had to correct on this key provision. She responded cheerfully that she did know what the law was, but continued talking as if it didn't matter.

This only confirmed the obvious: that knowing literally what the law says, on the one hand, and understanding the rationale behind it and approaching clinical situations accordingly, are two different things.

It's the mindset and the decisions that flow from it that count.

By the same token, a mindset that doesn't recognize you don't, ever, wait for dangerousness – you focus on the illness right away – lends itself to disaster.

Kamloops homicide case a sad and bitter reminder

We're reminded of this again by the trial in Kamloops this month of 19-year-old Joshua Steel who, following instructions from the devil (command hallucinations), beat his father to death in September 2011. Young Joshua was clearly ill and had been having difficulty for some time. Among other things, he was hearing voices and also commands from a television set.

Just two days before he attacked his father, he had broken windows of cars in his neighbourhood after an argument with his parents. His mother wanted him in hospital, but a mental health worker who interviewed him at the time said there was nothing to indicate he needed to be certified.

It seems baffling this could have happened. Was the mental health worker looking for overt dangerousness instead of concentrating on the illness and its symptoms, and the need to get Joshua into hospital because he was ill?

Such errors of judgement don't just occur in a vacuum. They stem from mistaken, counterproductive attitudes that need to be sorted out.

No urgent outreach an obvious deficiency

The North Shore mental health worker might have responded differently to the call she received had there been urgent outreach – a team she could have sent out to see the condition of the ill person themselves, consult with the family directly, and decide whether hospitalization was called for.

It's a continuing disgrace that no such outreach is provided on the North Shore and Sea to Sky.

Vancouver has urgent outreach – Car 87, consisting of a mental health worker and a police officer. Richmond has urgent outreach. Surrey has urgent outreach (Car 67). Nanaimo has urgent outreach. The North Shore and Sea to Sky don't.

Some years ago, a proposal was floated internally to fill the gap. It borrowed from the Richmond example where, instead of a two-person team – the scale of operation didn't justify it – a nurse responded to calls on his or her own, taking a police officer with them only where there was some risk. The hours of availability (11 a.m. to 11 p.m.) were also slightly less.

It was an inventive, low-cost solution waiting to be adapted for the North Shore, but Mental Health Services didn't follow through.

They instead shuffle callers off, referring them to the police. Reliance on the police alone, however, is a poor, second-best option, aside from the outsized burden it places on police time.

Police intervention, for a start, is limited to cases of "likely to endanger." While that one word, "likely," allows for considerable discretion, where an officer can make a judgement based on a pattern of behaviour without having to see dangerousness at the scene, it still leaves many quite ill people prey to their illness and worse.

A psychiatrist brought in by an urgent outreach team, on the other hand, can, where appropriate, certify

someone "to prevent the person's substantial mental or physical deterioration," which does address the illness and also, in that way, reduces the likelihood of a suicide attempt as well.

Police officers, moreover, although they can make good common-sense judgements – and many have a lot of experience – don't have psychiatric training.

Mental health services without urgent outreach an emasculated service

North Shore mental health services don't seem to realize that without pro-active outreach, especially for those without insight who won't come in, they're an emasculated service that will never do its job well.

Outreach should be an integral part of the community care system, catching psychosis early to prevent acute exacerbation. Working with family members as team partners should also be part of the outreach protocol.

There is occasional outreach in the case of patients already under the care of community mental health, but it's spotty and usually last minute, when deterioration is far along and dramatic enough that someone can be convinced, or badgered, to come out, and that depends on a family member or friend having the fortitude to persist.

The usual response, in NSSS experience, is "He's got to come in," or "We're a voluntary service," and, if the person ultimately fails to come in, the file is closed. This is quite unrealistic, especially for people who are decompensating because they don't have insight and have stopped taking their medication.

They're not going to come in, yet they need help more than those who do. It's almost as if the system doesn't appreciate what serious mental illness is.

Ideally, moreover, a psychiatrist should lead urgent outreach instead of, for example, a caseworker and police officer going out first and having to call in the psychiatrist later.

This would also ensure that the broader and more realistic medical criterion for intervention would be at play rather than the limited police criterion.

Families are driven to often desperate measures

The absence of outreach is yet another missing link in the kind of continuity of care that is needed to get seriously ill people truly stabilized.

It can have perverse, as well as tragic, consequences.

Where harassment, threats, breakage, stealing money from the family, or other such incidents occur, because the person is ill, families may now be advised to have charges laid – say a mischief charge – in order to get their ill relative into the justice system.

The idea is that with court orders and even, it's sometimes hoped, assignment to Forensic Psychiatric Hospital (FPH), something effective and enduring will finally be done.

The advice may come from a police officer, a counsellor, a GP, and even someone in mental health services itself.

However, unless it's a serious offense, which is going to go to court anyway, a stay in forensic hospital is not likely to happen, and often all a charge and court procedures do is move the revolving door to the justice system.

Criminally charging people to get them the care and treatment they need, where there are already hospitals and mental health services in their community, is, when one thinks of it conceptually, just bizarre.

Yet we can understand, in the circumstances, why it occurs.

When this kind of thing happens, we're moving beyond particular mistakes and inadequacies in mental health services to a more deep-seated dysfunctionality.

Inquiry in Amer case gets down to details

Psychiatrists and not Emergency Department (ED) doctors should be in charge of decisions as to whether somebody who is mentally ill and brought to Emergency should be released or kept in hospital.

That's just one of 22 recommendations by the independent inquiry into the Mohamed Amer case at St. Paul's Hospital.

Early this year, Amer, quite ill, was taken to St. Paul's twice in the same day by Vancouver police, only to be released by the hospital on both occasions. The next day he stabbed a complete stranger in a coffee shop (fortunately, the elderly victim survived).

NSSS support coordinator Marguerite Hardin spoke to the inquiry team at a meeting in the spring.

The report of the review was made public in August.

Such reports are maddening because, due to limitations in what they can say about personnel – virtually nothing – they don't report what actually happened in the hospital (who did what and why).

By reading between the lines, though, one can make an educated guess.

- Most likely, Amer was released by ED doctors without having even seen a psychiatrist, hence the recommendation that "the secure observation unit in ED should be managed and overseen by Psychiatry."

NSSS has a similar concern with Lions Gate Hospital, where the non-specialized head of Emergency rather than the PEN (psychiatric emergency nurse) decides whether to bring in the psychiatrist on call.

- Also recommended: "Patients taken to hospital under Section 28 [the police provision] should be held long enough to complete an appropriate assessment."

That the review team should have to bother pointing this out says a lot in itself. Isn't an appropriate assessment what the whole procedure is about?

Police in both Vancouver and the North Shore have long complained that in some cases people they bring to hospital because they were so ill show up on the street almost immediately afterwards.

- The review team also points out, however, that St. Paul's, whose emergency department registers 73,000 people per year, needs more psychiatric resources. The report underscores as well the deep commitment of hospital personnel to help get those suffering from mental illness better.

St. Paul's handles most of the more difficult cases in Vancouver, including homeless mentally ill with substance abuse problems from the Downtown Eastside.

For a full copy of the report, search "VCH external review report" and follow the links.