NSSS ADVOCACY BULLETIN

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Government ministry keeps mother in the dark

In a case NSSS has been working on, the Ministry of Children and Family Development is refusing to share information with the mother of a young woman who has previously attempted suicide and who is under their care, via a "youth agreement," having left home.

The refusal is continuing although it has been established that the mother is not at fault and although psychiatric best practices call for both information sharing and the involvement of the mother in diagnosis and providing other feedback. For the better part of a year, ministry officials repeatedly denied they could share information with the mother without the daughter's permission, which she has not given. The applicable legislation, however – the Child, Family and Community Service Act (CFCSA) – quite clearly states that they can in fact do so if "necessary to ensure the safety or well-being of a child [or youth]."

In the case of someone who has attempted suicide and was thought by her GP to be bipolar, both her safety and her well-being are at issue.

When finally forced to admit that, well, yes, the Act does allow them to share information with the mother after all, ministry officials still have refused to do so, claiming among other things that it's not permissible under the act, although they had just admitted the contrary.

The mother has not even been told if the daughter has been assessed by a psychiatrist or is taking medication, although it has been learned indirectly that a psychiatric assessment has probably been done.

In NSSS's view, a proper diagnosis cannot be completed, and the best medication assigned, without the psychiatrist talking to close family members about the person's history and also getting their feedback on more recent patterns of behaviour. Ministry officials have not denied that best practices call for such information sharing, they've simply declined to follow through.

Neither the mother nor NSSS can raise this question directly with the psychiatrist, because we don't know who the psychiatrist is.

In addition, some ministry workers have been all too ready to condemn the mother, without justification and despite ministry policy not to exclude family members where possible.

NSSS will continue to pursue this issue.

Delta case raises questions; NSSS called to comment

The case of a 53-year-old Delta man, who was killed when hit by a vehicle on Highway 17, then by a bus and dragged in the bus's undercarriage, has raised questions again about the way the mentally ill are sometimes handled by hospitals and police.

The police had earlier taken the man to the police station because of his odd behaviour, thinking him drunk. He had been loud and obnoxious. When, however, after four hours, he didn't appear to sober up, they took him to Delta Hospital. While waiting to be looked at, the man wandered over to a nearby recreation centre where he created a commotion. A different officer, unaware of what had happened earlier in the day, intervened and, judging the man to be lucid and able to care for himself, took him to a bus stop.

The man returned on his own to the hospital, however, but after waiting another 90 minutes to be seen by a doctor, he wandered away again, after which the fatal incident occurred.

Questions immediately arose as to why one of the policemen, when they had originally taken the man to the hospital, did not remain with him until he had been taken in charge by a doctor.

Called by the Globe and Mail, covering the story, NSSS president Marguerite Hardin said that every police officer should have some training on what mental-health problems look like. "Unfortunately, they have been put in this position of being the front-line workers quite often. Some are very, very good; others need more training and understanding about what they might be dealing with," she said.

A Delta Police spokesman, quoted by the Globe, said the police did not know whether the man had mental-health problems. That would be up to the hospital to decide.

The Delta Police Department has one officer on its force specifically trained to deal with the mentally ill, the police spokesman added. Police would have made an effort to call the officer if they considered the man to be extremely mentally unstable, he said. The officer would be brought in "only if it is something really out of the ordinary, which this one wasn't."

Department's explanation only begs the question

The Department's explanation, however, only begs the question, in NSSS's view. It's not clear, as of this writing, that the man in fact was mentally ill, as different from the impact of a small stroke or some other neurological malfunctioning. Given his behaviour, however, the possibility was there. In such circumstances, it would have been desirable if an officer had stayed behind until a physician had taken over, which is standard practice in cases involving the mentally ill.

Similarly, someone who, for no apparent reason, makes a disturbance at a recreation centre on the face of it likely needs help.

Having just one officer trained to deal with the mentally ill, moreover, is also inadequate. Calls involving the mentally ill are a significant part of police work, where the judgement of officers working a particular shift, on the spot, comes into play. These are sometimes difficult judgements to

make, so sufficient training is important.

Both the North Vancouver RCMP and the West Vancouver Police Department appear to recognize this. Recent NSSS presentations to the two police forces were given to all shifts (the RCMP call them "watches'), and it was clear at these presentations that calls involving the mentally ill were something they all felt they needed to be prepared for.

Long Emergency waits are another serious problem

Another factor contributing to the man's death were the delays at Delta Hospital. The triage nurse on duty considered the man not to be at risk, hence low priority, and in the several hours while he was waiting he wandered off twice, the last time being fatal.

Wait times for the mentally ill in Lower Mainland emergency wards are a continuing problem.

When police intervention under the Mental Health Act is involved, the delays tie down police officers who are required to wait with the ill person until they are signed off by a psychiatrist or other doctor.

This acts as a disincentive for the police to take someone to hospital for an assessment. Under Section 28 of the Act, which gives police the authority to intervene, officers have a certain amount of discretion. Even the most conscientious officer, in making a decision whether to apprehend or not, is going to have in the back of his or her mind the possibility of a long wait in hospital just standing around.

(The frequent failure of psychiatric wards to keep people in hospital until they're properly stabilized is another disincentive for police.)

The waits also pose a problem when a family member manages to coax their ill relative to go to emergency with them voluntarily. If the person is agitated or hesitant, it's touch and go whether they'll stay for an assessment if they have to wait a long time.

The same applies when the ill person goes to emergency on their own. They may just get tired of waiting.

NSSS encourages the police to be pro-active in helping the mentally ill by taking them to hospital when needed regardless of how the hospital subsequently handles them. We urge them not to be discouraged by long waits or by seeing someone they've brought to hospital, because that person was obviously in difficulty, back on the street the next day.

Shortening hospital waits for police is something both the police and NSSS have long advocated.

THE CRISIS FILE

"Right now he's not suicidal; there's nothing else we can do," a Community Psychiatric Services worker told the mother of an ill young man who was decompensating, lacking insight and becoming psychotic again.

It's the kind of response family members often get in Greater Vancouver, but as many of them know, it's incorrect. A person doesn't have to be suicidal to be committed. "To prevent....substantial mental or physical deterioration" is the lead criterion for committal in the BC Mental Health Act.

Waiting for someone to become suicidal, moreover, is too dangerous. A person who is psychotic can go from not being suicidal to committing suicide very quickly, before intervention is possible.

It's exactly to help family members advocate for their loved ones in such critical situations that NSSS has added key sections to the Crisis File – the duo-tang booklet distributed to those taking our Family-to-Family Education Course.

The added sections cover involuntary committal, police intervention and information sharing respectively. They make the following points:

1. Involuntary committal. As detailed above, dangerousness is not required for committal. Indeed, the word "dangerousness" does not appear in our Act in BC. The need "to prevent.... substantial mental or physical deterioration" is grounds for committal.

NSSS encourages those trying to get an ill relative into hospital to have a copy of the committal provisions on hand when dealing with service providers (Emergency, CPS and so on). If they're told, wrongly, that their relative can't be committed because they're not suicidal or "dangerous," they can cite what the committal provisions actually say and, with a log documenting their ill relative's need for treatment, help make the case for committal.

2. Police intervention. Under Section 28, police can apprehend someone for an assessment if they're "acting in a manner likely to endanger that person's own safety or the safety of others."

As the Crisis File explains, the key word in this provision is "likely." A person doesn't have to be holding a knife or uttering threats of violence to be apprehended when the police answer a call. "Likely to endanger" is a much broader concept which takes into account what might happen given the person's condition and recent pattern of behaviour. Anyone who is psychotic, confused, or otherwise unstable is at risk.

Another key clause in Section 28 is that the police can act on "information received," in other words, on the observations of family members. They need not depend only on what they see right at the moment when they appear on the scene.

3. Information sharing. Under the provisions of the Freedom of Information and Protection of Privacy Act (FIPPA), service providers can share information with family members even without the patient's permission, if required for continuity of care or if someone's health or safety is at risk.

In practical terms, this leads the way to the sharing of information with family members who are involved.

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The new NSSS sections of the Crisis File, addressing these critical issues for families here on the North Shore, are also used elsewhere in the province where Family-to-Family is taught.

FEEDBACK WELCOME

This is the first issue of the Advocacy Bulletin, which we hope will be a regular feature of The Notepad. We welcome your comments on anything you read in the Bulletin. If you have a story of your own you would like to tell us about or bring to our attention, please also get in touch. You can drop by the Family Support Centre, call us at 604-926-0856, or email us at advocacy@northshoreschizophrenia.org.