Supporting families dealing with serious mental illness

NORTH SHORE SCHIZOPHRENIA SOCIETY

Case histories involving failure to share information

Following are a few case histories of the tragedy resulting from professionals' refusal or failure to share information with family members or otherwise to communicate with them. The case histories are drawn from across Metro Vancouver. Fortunately, professionals who won't talk to families and share information with them are gradually growing fewer in number.

Case history 1

A young man is in hospital and is pronounced ready for discharge. His mother, from long experience and knowing her son's clinical history quite intimately, picks up clues that his delusions are just under the surface. The psychiatrist, however, refuses to discuss the issue with her or to share observations. The patient is discharged prematurely. Before long he deteriorates and ends up with "command hallucinations" driving him to a suicide attempt with near-fatal results.

Case history 2

A man whose mother had been keeping the truth about his illness from other family members and done her best to protect him from the consequences of his delusions begins to seriously decompensate following her death. Unable to sleep in the family home left to him because he believed there were gases being pumped into the house and he was being spied on, he sleeps in his car. During the day, he barricades himself in the house, even threatening violence against a relative who comes over to see how he is doing. Police and a mental health worker who come to assess him note that the house is in complete squalor and the man is quite delusional, believes that his medication has been tampered with, and may even be contemplating suicide. Even so, they conclude that the man's sister only called them in because of a 'dispute over property' and they close the file. The man spends inappropriately on strange items he doesn't need and cannot afford, but his mental health team - who are aware that he has been off medication for many months - doesn't seem to think it relevant and again dismisses the sister's concerns. Effectively homeless following the sale of the family home, he starts living in his car and, again, the mental health team dismisses his sister's concerns about his mental decompensation. The only person who listens is the Superintendent of Motor Vehicles, who revokes the man's license after he has four crashes in the space of a month. After many months and several missing persons reports, the man agrees to call his sister regularly. Meetings between them seem like something from a spy novel as he calls her three or four times while she is on her way to change the meeting place. His family contacts a lawyer, who brings their concerns about his increasingly paranoid and alarming behaviour to the mental health team. Another assessment results in no change - he is "not dangerous." The B.C. Mental Health Act is misquoted to the family - they are told there is "nothing they can do," even

though the mental health team knows he is very ill and would benefit from medication. Less than a month later, the man jumps to his death from the Granville Street Bridge.

Case history 3

A psychiatrist and therapist on a mental health team refuse to talk to a patient's family without the patient's permission, citing the need to build trust with the patient and, with that, a strong relationship. Unfortunately the patient has limited insight together with paranoid thoughts about his family and won't grant that approval. The team argues that their special relationship with the patient is necessary to keep him coming back to the team for his medication, which is given to him by injection. The family, familiar with the patient's history and seeing recurring psychotic symptoms, knows better but, with the taboo on communication, has no way of getting this across. The patient is on "extended leave," where, although discharged from hospital, he is still legally "committed" and is obliged to take his medication. The team, however, doesn't bother renewing the extended leave. Predictably, in this case, the patient doesn't come back for his medication, and when the distraught family shames the team into making a call on their ill relative, he tells the team to "f... off." The special relationship, excluding the family from the treatment process, doesn't hold up for even a few weeks. After that, the team no longer bothers. The ill relative becomes wildly delusional, and the family is left to pick up the pieces. Their persistent efforts, including an emergency call to the police, result in his being recommitted, but much damage has already been done. The profound psychotic break, which should have been avoided, keeps the ill relative in hospital for another 18 months and, because of the break, his subsequent level of recovery is less than it would otherwise have been.

Case history 4

A young man with schizophrenia is sharing an apartment in dedicated psychiatric housing with several other "ex"-patients. The organization in charge of the housing believes in "respecting the client's wishes." The young man, however, goes off his medication and shows other worrisome signs of a major relapse. When he attempts suicide, following a classic pattern - giving away his possessions and taking a room in a hotel where he takes an overdose - nobody informs his family. The family, meanwhile, aware that their son is deteriorating, but getting no real help from the care team, in desperation decides to try a "tough love" approach, in hopes that their son will listen to them and get back on his medication. They tell him they can't help him financially any more until he goes back to see his psychiatrist and starts his medication again. Had they known of the recent suicide attempt, they would have never taken that approach and also would have been able to argue more forcefully for proactive care-team intervention. Shortly after, the young man returns to the shared apartment, but in his deteriorating condition, he has difficulty fitting in. His roommates tell him his behaviour is not acceptable and that he can't stay there any longer. The young man makes his way to a wooded park where he hangs himself from a tree branch.

Case history 5

An 18 year old female student at the University of British Columbia in Vancouver attempts suicide and is hospitalized. The health providers subsequently release her without contacting next of kin. They do give her a phone number for the university's mental health team but make no attempt to ensure that she follows through, which she doesn't. The woman's mother lives in Portland, Oregon, a mere five hour driving distance or an hour's flight away. A month later the daughter commits suicide in her dorm room, and her mother is informed by the RCMP about what has happened. The mother is distraught. She learns for the first time about the earlier suicide attempt. Had she known of that initial incident, she would have rushed to her daughter's side. Now it's too late.

The media discover the story. Both a hospital spokesperson and the UBC Vice-President for Students claim that confidentiality provisions did not allow them to inform the mother of the first suicide attempt. It is evident from these explanations that those responsible don't know much about the applicable Freedom of Information and Protection of Privacy Act (FIPPA) or have misinterpreted it. They certainly hadn't paid heed to the Ministry of Health's fact sheet on the Act which makes it clear that such information can, and should be, shared in such circumstances, where someone is at risk and where family involvement is important to "continuity of care." Both the health providers and the university were derelict in their failure to notify the woman's mother, who could have provided much-needed support and may well have prevented her death.