A Reason to Hope. The Means to Cope.
British Columbia Schizophrenia Society
BC Schizophrenia Society Foundation
Supporting the BC Schizophrenia Society

January 31, 2014

The Honourable Terry Lake
Ministry of Health
PO Box 9050 Stn Prov Gov
Victoria, BC V8W 9E2

Dear Minister Lake,

The BC Schizophrenia Society is currently in the process of reviewing recommendations relating to mental illness made by the BC Coroners Service. As an organization dedicated to supporting families coping with mental illness and its devastating effects, the BC Schizophrenia Society has a keen interest in recommendations that can improve responses to mental illness within the health and justice systems.

I am writing to inquire how the Ministry of Health has responded to the recommendations noted below:

Inquest held at the Coroners Court in Burnaby, BC March 11th and 12th, 2013 into the death of Duncan Leslie Roy Smears (File No. 2011:0278:0202)
http://www.pssg.gov.bc.ca/coroners/schedule/archive/2013/docs/verdict-smears-2013-03-12.pdf

Recommendation:

That there should be established a working group involving organizations such as Vancouver Coastal health, Providence Health Care, Vancouver Police Department, Covenant House and other stakeholders to provide coordinated mental health services to adolescents and youth.

Coroner's Comments: The jury heard testimony that many individuals between the ages of 19 and 30 "fall between the cracks" as they transition from the child mental health system to the adult mental health system. Evidence was heard that this age group has particular needs that are not being addressed during this transition period. They also heard that the information that was obtainable to the police through Car 87 was incomplete, as P.A.R.I.S. is not consistently used across health authorities, hospitals and community medical facilities.

Inquest held at Western Communities Courthouse in Colwood, BC December 12th to 16th, 2011 into the death of Hayden Blair Kozeletski (File No. 2010:1007:0110)

http://www.pssg.gov.bc.ca/coroners/schedule/archive/2011/docs/jury-findings-kozeletski-dec-16-2011.pdf

Recommendation:

That an inter-ministerial liaison be appointed to assist families in navigating the mental health system in British Columbia.

Coroner's Comments: The jury heard evidence that when Hayden began to demonstrate emotional distress in conjunction with her sexual abuse disclosure, several agencies became involved with the family which caused confusion for the family. The agencies had mandates which were in some ways similar but dissimilar and it became unclear for the family as to who was there to help Hayden and how.

Recommendation:

That the Mental Health Act be amended to remove the automatic expiry of certification upon the passage of 48 hours.

Coroner's Comments: The jury heard evidence that Hayden's certification under the Mental Health Act was not renewed between her discharge from Campbell River General Hospital and Ledger House.

Inquest at Coroner's Court in Burnaby, BC December 13th to 17th, 2010 into the death of Paul Glenn Boyd (File No. 2007:270:0809)
http://www.pssg.gov.bc.ca/coroners/schedule/archive/2010/docs/verdict-boyd-2007-0270-0809.pdf

Recommendation:

We recommend mandatory utilization of extended leave, as defined in the Mental Health Act, for a person(s) suffering from a serious mental illness to ensure the person's well-being, mental health, and safety of the public.

Coroner's Comments: The jury heard evidence that Mr. Boyd may have benefitted from increased medical supervision and more readily available access to medical care in the community.

Inquest held at the Coroner's Court in Burnaby, BC June 1st to 10th, 2009 into the death of Ross Alexander Allan (File No. 2008:0369:0149)
http://www.pssg.gov.bc.ca/coroners/schedule/archive/2009/docs/verdict-allan-10-june-2009.pdf

Recommendation:

That all members of the health care team are trained that all MHA patients are for the most part, unable to provide true and accurate information on themselves. Therefore, the team must obtain and chart relevant collateral information from the family and/or other sources.

Recommendation:

That the Mental Health Act be revised to allow at the Psychiatrist's discretion, family members access to information, diagnosis, and inclusion in the treatment plan.

Recommendation:

That a patient's family or contact person is notified as soon as possible when a patient is determined to be missing as per Code Yellow Stage One procedure.

Recommendation:

That every effort be made to reduce the stigma of mental illness among young adults.

Recommendation:

That a process be developed for early detection of young people at risk of developing mental health issues.

Inquest held at Supreme Court of British Columbia in Vernon, BC November 12th to 14th, 2008 into the death of Christopher Paul Klim (File No. 2007:0562:0069)
http://www.pssg.gov.bc.ca/coroners/schedule/archive/2008/docs/verdict-klim-file-07-562-0069.pdf

Recommendation:

That a Provincial policy be developed regarding the apprehension of patients and/or clients with mental illness history when requesting police assistance.

Coroner's Comments: The jury heard evidence from Mental Health witnesses that there is no standard protocol in place; once Police were notified in this circumstance of the warrant to apprehend, the matter was basically turned over to them pending apprehension.

Recommendation:

Mental Health Warrants forwarded to the local police for execution will include an information check list, including but not limited to the following.

i. Details and descriptors of the patient and/or client.
ii. Known residences or potential locations to be found.
iii. Description of mental illness history, behavior and potential response to authority.
iv. History leading to the issuance of the Mental Health Warrant.
v. Mental Health contact person information.
vi. Other comments.

Coroner's Comments: The jury heard evidence from both Mental Health and Police witnesses who acknowledged the value of detailed information sharing and communication in these types of circumstances.

Recommendation:

Upon forwarding a Mental Health Warrant to Police the Mental Health contact person shall notify patient's and/or client's contact family members.

Coroner's Comments: The jury was presented with evidence that demonstrated the need for and assistance that family can provide to Mental Health and Police agencies that will assist bringing that client/patient to medical care.

Inquest held at Burnaby Coroners Court in Burnaby, BC November 13th to 15th, 2012 into the death of Colette Marie Salemink (File No. 2010:0364:0124) http://www.pssg.gov.bc.ca/coroners/schedule/archive/2012/docs/verdict-salemink-2012-11-15.pdf

Recommendation:

If a caregiver provides support for a mentally ill person they should be supplied with a detailed list of information of the resources that have been made available to the mentally ill person. Such as community services, local housing, legal help and local support. The caregiver should also be supplied with their legal options (i.e. Peace Bond or Restraining Order) and any other resources that may help them support themselves as well as the mentally ill person in their charge.

Recommendation:

If a Caregiver wishes to alter the conditions of 'the extended leave' then the psychiatric team or psychiatrist needs to ensure that the Caregiver's wishes are adhered to within 24 -36 hours. For example if the Caregiver is no longer willing to allow the patient to reside at their residence it is the duty of the team to immediately find alternative accommodations. An updated Form 20 needs to be completed and submitted to all necessary parties (i.e. CPIC, Prime and medical authorities) within 48 to 72 hours.

I appreciate your attention to this request and look forward to receiving a response by February 28, 2014.

Sincerely,

Dave Halikowski
BC Schizophrenia Society Chair