

**The Salvation Army**

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"Giving Hope Today"

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The Standing Committee on Families and Communities
c/o Committee Clerk
3rd Floor, 9820 - 107 Street
Edmonton, Alberta
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November 16, 2015

Dear Committee Members:

RE: Review of the Mental Health Amendment Act, 2007

Thank you for your invitation to provide input regarding the changes introduced by the *Mental Health Amendment Act, 2007*.

The Salvation Army in Alberta has a proven track record of providing care and support to persons with mental health issues in communities across the Province. We count it a privilege to work collaboratively with various Ministries of the Provincial Government (Health, Human Services, Justice & Solicitor General, Seniors) as well as our partner agencies and care providers.

The attached document serves as our input into the Review. We would welcome further dialogue as well as opportunity to be further engaged in this important and challenging task.

Kind Regards,

W. Mark Stanley - *Captain*
Government Relations Officer

Involuntary Admission

To be effective and legitimate, Involuntary Admission should lead to a goal of discharge into ongoing, supportive care and the greatest level of independence the individual can achieve with those supports. This requires a long-term commitment on the part of government to fund the ongoing treatment and support required at discharge that ensures the patient will receive the care they need to break free from the cycle of re-admission. Without that commitment, the efficacy of the Involuntary Admission intervention will have little or no long-term positive impact and will not deliver the anticipated, desired outcomes.

For some, Involuntary Admission will look similar to incarceration. While one might be able to articulate the legal distinctions between the two, there is a significant likelihood that this distinction will be lost when an affected individual, or their family, believes that the detainment is unjust or unwarranted. Therefore, Involuntary Admission should include a process whereby individuals and their families are involved in care planning and determination of desired outcomes for the individual who is experiencing Involuntary Admission.

Individual Rights and Community Rights

It is our understanding that under the Mental Health Act a health care provider would normally start by seeking consent for treatment from the individual if he or she is competent. Competence under the Act means that the individual has decision-making capacity, and/or consent is provided by a competent individual before treatment is provided

Agencies contracted by Government to deliver services may find themselves in a vulnerable position where they feel unprotected. Government funding contracts typically stipulate that the agency comply with current legislation, but that compliance does not protect the agency from challenges/complaints an individual in their care may make. Example: funding is provided to an agency to deliver services based on certain criteria of care. An individual receiving service refuses to comply with treatment requirements, e.g. attending a meeting with a Social Worker or comply with housing rules/policies. The individual may see these requirements as an infringement on their Human Rights, and when these cases/claims go forward, agencies are typically left to fend for themselves, incur significant legal costs, and have little or no support from the funder/supporting body.

One of the outcomes is that agencies have no other recourse than to allocate significant resources toward risk mitigation - resources that perhaps could and should be directed toward direct client care. Given that certain provisions within the Mental Health Act can have the effect of superseding individual rights, and that the legislation also creates a number of checks and balances to protect individuals, where possible the Act should also provide appropriate protection for the agency/entity and individuals providing care.

Aboriginal Community Distinctiveness

Alberta is home to the third largest Aboriginal population in Canada with 220,700 Albertans self-identifying as Aboriginal (Government of Canada, 2011). The impact of changes to the *Mental Health Act 2007* must take into account both the history and present experience of our Aboriginal people and their communities.

“Many Aboriginal people understand the causes of contemporary suffering as rooted in the history of colonization and subsequent cultural oppression, including the impact of sedentarization, forced acculturation, and residential schools. They thus see their individual and collective difficulties as consequences of historical trauma.

Because of the pervasive effects of cultural oppression and historical trauma, many Aboriginal people see their situation as requiring an ongoing process of individual and collective healing. This may involve efforts to re-connect with family and community, to live on the land, to recollect and preserve traditional knowledge, and to affirm cultural values and identity. It includes active efforts to regain political control and find creative ways to embrace spiritual values while meeting the challenges of a globalizing world.

This process of healing does not involve Aboriginal people alone, but calls for reflection and action by the larger society. Health, then, is not a static state of well-being, but a process of achieving harmony, balance and connectedness within oneself and in relation to others.” (Government of Canada, 2006)

This raises a pointed question about Aboriginal persons and detainment: How does Involuntary Admission not look like an intervention that harkens back to the tragic history and impact of residential schools, forced relocation, and loss of community?

A possible way forward is to:

1. Ensure representatives from the Aboriginal Community are given opportunity for input to the Mental Health Act amendments/changes
2. Ensure that when Involuntary Admission involves the detainment of an Aboriginal person, there is well defined, intentional representation/involvement from the Aboriginal community in the process.
3. Ensure representatives from the Aboriginal Community are involved in the CTO process so that the process of individual and collective healing includes an Aboriginal context

Legal Representation & Advocacy

There are significant challenges when legislation attempts to balance public protection with the protection of individual rights. Historically, and currently, the means to achieve this balance has been to ensure the individual in care has access to both legal and advocacy resources. While this provides a measure of protection for the individual, it can also have the unintended consequence of setting up an adversarial dynamic the caregiver and the person receiving care that can negatively impact care outcomes.

The first and primary task of legal representation is to act as an agent to represent the interests of a person or group, as defined by that person. Individuals who cause harm to themselves or to others may not be in a position to determine what is in their best interests, their family’s best interest, or the best interests of the communities impacted by their behaviour.

Similarly, the primary task of the Mental Health Patient Advocate, is represent the interests of the individual by investigating complaints from, or relating to, patients, both those detained under one certificate or formal patients or persons subject to a CTO. The Mental Health Patient Advocate also has the power to initiate an investigation without a complaint.

Both of these interventions come “after the fact”, are reactive rather than pro-active, and are responses to infringements, perceived or real, on the individuals human rights that have already transpired. Perhaps a better way forward would be to involve legal and advocacy representation from the outset and insure they are part of the Care Team for patients who experience Involuntary Admission and/or CTO’s. Their task would be to protect and serve the best interests of all persons involved: ensuring the patient’s rights are maintained from the outset, due diligence is carried out, and the care staff (and the agency/employer) are supported and advised as needed.

Complaint processes ensure a measure of transparency and help address situations where there is an inherent imbalance of power. These processes by their very nature can place an onerous and heavy burden on individuals and/or agencies providing care, requiring substantial documentation of care given, detailed policies and procedures, and steps that mitigate risk. To lessen the chance of a complaint being judged as legitimate, caregiving agencies typically engage in preventative, risk management activities that will shield them, that add time and cost to treatment procedures and often add little benefit to actual patient care.

It is normative that care staff, who apply their best judgement in a variety of settings and with immediacy, will encounter situations where they must choose between two or more possible treatment responses, e.g. giving a sedative to calm an agitated patient or choosing to wait and see if the patient is able to calm down on their own. Without adequate protection, care staff may be reluctant to intervene without approval, with the outcome that patient care suffers. What happens if in the judgement of treatment staff a patient requires a certain intervention, and the patient refuses? While waiting for a physician with the authority to override the patient’s wishes, the agency delays treatment and during that waiting period, the patient harms themselves or a staff person. The issues of responsibility for care, on one hand, and liability, on the other hand, become very complex.

Protection for All

The Oct. 5, 2015, transcript (29-1-2) of the Standing Committee on Families and Community, details a discussion regarding patient concerns. The concern was expressed that the patient’s “clear instructions under their directive differs from the treatment decisions by the substitute decision-maker under the Mental Health Act” with the recommendation that “the [Mental Health Act] should be amended to address the conflict between the provisions of the Personal Directives Act’s clear instructions and the Mental Health Act’s best interests as set out in the criteria” (pg. FC-13).

This presents significant challenges in terms of precarious position in which it places caregivers. It is possible that an individual who has been detained because they are “likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment” (FC-8) may take legal action or file a Human Rights complaint because their own directives about treatment have not been followed. This raises questions about how the Act will protect the patient’s rights while also mitigating the liability of a caregiver or caregiving entity, and will also allow treatment action to supersede patient rights when it is in the best interest of the patient and those in the community in which the patient resides.

Community Treatment Orders (CTO)

A CTO will likely be most effective when it requires the patient to have ongoing, regular (daily) contact with treatment/care staff. However, where there is non-compliance - particularly in cases where the patient has a dual diagnosis (both mental health and addictions issues) the likelihood of voluntary compliance can be low and discharge to their own recognisance typically results in the cycle of readmission beginning all over again. Therefore, we would recommend that any individual who is discharged from Involuntary Admission with a CTO, be discharged to a care facility where they will continue to receive the supports and care they need to comply with the CTO until they are able to transition to a more independent situation.

It is our experience that for many chronic, dual diagnosis users of the health care system, 'success' in living in community requires ongoing, daily support from caregivers. It is unlikely there will be any positive modification in an individual's behaviours beyond what they can sustain cognitively or sustain because of ongoing intervention from care staff. In many cases, this means lifetime support, but if managed well, it will still reduce and/or eliminate the repeated pattern of admission, stabilization, discharge, deterioration, and repeated readmission that is the current reality. With ongoing, daily support we see individuals with dual diagnosis experience improved mental health, medication compliance, improved social and community engagement, and better quality of life.

In many health care and addictions settings, we see positive change when the patient is given a 'place at the table' and opportunity to speak into their Care Plan. We recommend language in the Act that allows and enshrines the same type of participation either from the patient directly, or if the patient is not capable, then from the Mental Health Patient Advocate. This would encourage a collaborative approach to providing the best patient care that is patient-centred.

Information & Transparency

In the interest of ensuring privacy, there has historically been an unwillingness to share information between those directly involved in patient care: caregivers, physicians, social workers, mental health workers, hospitals, and caregiving agencies. Caregivers and entities delivering care, require more access to patient care records. Without the sharing of information we see patients having to repeatedly tell their story and a significant duplication of information gathering work by caregiving staff, with the result that patient care suffers because the 'right-hand does not know what the left is doing'. Dr. Swann raised this issue in the Oct 5, 2015, meeting of the Standing Committee on Families and Communities, and we support the recommendation that the Act be amended to allow for an increased, appropriate level of access to patient information. Rather than restricting access as the primary means to ensure privacy, we would recommend a heightened clearance process for caregivers that would clearly define expectations and describe appropriate consequences for privacy breaches.

Sources

Government of Canada. (2006). *The human face of mental health and mental illness in Canada 2006*. Retrieved from Public Health Agency of Canada: <http://www.phac-aspc.gc.ca/publicat/human-humain06/15-eng.php>

Government of Canada. (2011). *Aboriginal Peoples in Canada: First Nations People, Metis, and Inuit*. Retrieved from Statistics Canada: <http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-011-x/99-011-x2011001-eng.cfm>