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Standing Committee on Families and Communities,
c/o Committee Clerk,
3rd Floor, 9820 - 107 Street,
Edmonton, Alberta, T5K 1E7

Dear Heather Sweet, MLA Chair, Standing Committee on Families and Communities,

Re: Review of the Mental Health Amendment Act, 2007 (MHAA, 2007)

Thank you for the opportunity to provide a submission with respect to the MHAA, 2007. The request for input from stakeholders referred to two specific areas.

(1) The criteria for involuntary admission of persons with mental disorders to health care facilities.

(2) The use of community treatment orders for persons requiring ongoing mental health services.

I make this submission on my own behalf as Interim Director of the University of Alberta, John Dossetor Health Ethics Center. The submission has been written with advice and after discussion with a variety of health care professionals, clinical ethicists, and lawyers. The focus of the submission is on the clinically related ethical implications of the MHAA, 2007 in terms of the above two areas.

While the amendments listed in your letter are very positive in spirit in terms of improving the care of persons with severe mental illness, it is difficult to predict how they will work out in clinical practice. It seems to me from an ethical perspective, that the need to ensure this aspect of the process is most important. To do so requires education about the central place of the ethical principle of *respect for persons* in all health care situations as key to making the MHAA, 2007 work well in practice for the benefit of persons with severe mental illness. Because of the extreme vulnerability of this patient population and the legal support of involuntary hospitalization under the MHAA, 2007, ethics education of health professionals, legal professionals, and a variety of other public and private sector employees is of utmost importance. This education should address common misconceptions concerning the competency of persons with mental illness with respect to their acute health care requirements, intermediate care plans, discharge planning and social support requirements. The involvement of clinical ethics committees or clinical ethicists in consultation needs to be emphasized as part of this educational process. Similarly health care professionals and patients / families need education about the importance of involvement of the Mental Health Advocate in patients with severe mental illness where serious disagreements occur and particularly in cases of involuntary admission – see J.H. v. Alberta Health Services (2015ABQB 316).

I will address each of the above areas under their specific headings.

Criteria for involuntary admission of persons with mental disorders to healthcare facilities

The expansion of the criteria to include ' mental and physical deterioration or serious impairment ' is very positive. This reflects an understanding of clinical situations in which a patient's own physical or mental health may be in an acute life threatening deterioration for which the patient totally lacks insight and refuses life – saving treatment. Examples include serious physical injury, diabetic ketoacidosis, septic shock, etc. In situations of this nature the MHAA, 2007 allows the life – saving treatment to be instituted under this specific amendment. This can now occur in the absence of any concerns about suicide or homicide as extreme examples of harm or danger to self or others.

The change in wording from '*danger* ' to ' *harm*' with respect to self or others has several ethical consequences. A first impression is that this involves a loosening of the criteria for involuntary admission, setting a ' lower threshold ' and thus increases the likelihood of a legally supported disregard for autonomy and for the basic human right of freedom. The notion of danger is clearer in most aspects than the notion of harm. Harm appears to be more subjective in nature and more subject to influences beyond the realm of immediate physical risk, injury or battery than is usually implied by the word danger. As such there is a worry that usage of harm rather than danger may entitle health care professionals to enforce admission of persons who are mentally ill based on the subjective perceived harms of others. Such harms might include physical emotional , psychological , of a very non – quantifiable nature that would not clearly apply to the word danger. In opposition to this ethical concern of disrespecting autonomy is the testimony that many patients with serious mental illness have serious concerns about the use of the word danger as being intrinsically pejorative to them as persons. It may be that the use of *harm* at a policy level allows for conversations between physicians and patients that appear less punitive and more open and neutral than conversations focused on *danger*. A delicate balance between these competing ethical concerns is required in the implementation of MHAA,2007.

The proposed criteria for involuntary admission under MHAA,2007, appear generally congruent with the ethical principles of beneficence, and non – maleficence. In terms of respect for persons as autonomous moral agents, the MHAA,2007,recognizes that removal of self – directed health care from individuals with severe mental illness requires extraordinary ethical and legal justification and must only occur in exceptional circumstances. In recognition of this MHAA,2007, requires implementation and documentation of a monitoring process with checks and balances to enable patients to question and appeal their involuntary admission to healthcare facilities. The onus must remain on the healthcare facilities to justify ongoing involuntary admission rather than on the patient to justify release. The ethical respect for autonomy and the legal right to self – determination and freedom must remain paramount for these very vulnerable individuals. A formal process of review and documentation of patient progress and a mechanism of appeal should be part of the MHAA,2007. The role of the Mental Health Advocate in such cases requires widespread education among health care and legal professionals.

In addition, a comprehensive pre and post discharge plan is necessary to ensure the safe transition of the patient from involuntary admission to being released from in - hospital care. In many cases this will require comprehensive liaison with other health care professionals, family and other community support persons, to ensure that ongoing health requirements are satisfied. However it must be remembered that *at discharge the patient is now competent and therefore autonomous.* As such any mandatory requirement of health care professionals or facilities to inform third parties of the patient's discharge must be regarded as unethical. Patients who have been placed under involuntary admission due to mental illness may not wish anybody else to be made aware of this very private personal information. At discharge they are automatically deemed to be competent and as such their wishes must be respected. This requirement to respect the patient's right to privacy should not prevent appropriate clinical discharge planning with family and community support as necessary to provide ongoing health care.

Community treatment orders (CTOs) for persons requiring ongoing mental health services

The use of CTOs is a welcome addition to the MHAA,2007, as it provides alternative care to seriously ill patients with less onerous ethical and legal concerns than involuntary admission to hospital. The provisions listed governing criteria for the application of a CTO include requirements for two physicians independently assessing the patient's suitability in addition to the MHAA,2007 criteria. It should be stipulated that these physicians should be knowledgeable in the diagnosis of severe mental illness and of the MHAA,2007 criteria for CTOs.

The CTO requirements for a description of the clinical care plan , of who is in charge of decisions, of the CTO duration, etc are excellent as these stipulations make each CTO patient specific rather than ' generic '. Similarly details of conditions under which a CTO may be prolonged or terminated should also be patient specific and undergo ongoing review. Documentation of patient progress under a CTO should be undertaken as a means of deciding the duration of the CTO. A formal process of review and a mechanism of appeal should be built into the CTO policy under MHAA,2007.

The shift of care from involuntary admission in a healthcare facility to care in the community under a CTO is welcome as it is in keeping with the ethical principle of respect for persons' autonomy and the legal right to self determination and freedom. However, this shift of care must be accompanied by adequate resources in the community in order to protect these very vulnerable patients from harm, and to ensure that the mental health supports that they need are provided. The risk is that a disproportionate burden of providing care will be placed on the patient's family and lay support persons rather than on appropriately qualified community health care professionals. This risk of shifting the burden of care at the policy level from one domain to another can have serious adverse ethical and clinical consequences for patients and families. While the spirit of the use of CTOs in MHAA,2007 is in keeping with improving the mental health of seriously ill patients, the details of the CTO implementation in practice require very careful consideration.

Yours Sincerely,

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