BACKGROUND

New mental health crisis response models aimed at connecting people to more effective and robust mental health systems are being considered and developed by many Canadian cities, including Ottawa. Caregivers are often at ground zero of the mental health crisis of their loved ones and so their perspective and the perspective of organizations serving those living with a mental illness are critical to the redesign of a crisis response. Failing to include these perspectives risks missing the mark.

The Mental Illness Caregivers Association (MICA), wishing to have input to the design of a new mental health crisis response for Ottawa, recently put out an 8-stage model with recommendations that describe the thoughts, feelings and expectations of caregivers when a 911 mental health crisis call is made. It was sent to caregivers as well as organizations serving caregivers and those living with a mental illness and/or substance use disorders, with the ultimate goal to dig deeper into caregivers' needs, to understand what other organizations are working on and the possibilities for collaboration.

Based on what was heard MICA developed an action plan that included a call to action in response to the 2011 commitment made by the province of Ontario to set up a task force to reform our laws on involuntary treatment and privacy. A first attempt was made to identify 'what is broken' and the reforms required including advocacy efforts focused on influencing change as set out later in this document.

THE PURPOSE OF THIS NOTE

Our intent is to involve others in a in a discussion on how best to effect change in Ontario's laws and practices on involuntary treatment and privacy.

Need to recognize that no one concern stands alone but rather, often, is linked to several related concerns

In short, the challenge ahead will be to untangle the complexity while reaching agreement on priorities with respect to addressing "what is broken" with the current system of determining voluntary/involuntary status as well as identifying the "need for reform"

UNTANGLING THE COMPLEXITY – UNDERSTANDING WHAT IS BROKEN

- **INVOLUNTARY TREATMENT – DEFINED**

Involuntary admissions to hospitals are regulated provincially. Two involuntary admission criteria are consistent across all jurisdictions: that an individual presents with a mental and/or substance use disorder and that without involuntary admission, presentation of the disorder itself results in likely harm.

A person can be found to be a harm to themselves or others, and therefore must be detained, but at the same time can be determined to have capacity to make treatment decisions for themselves and to refuse treatment. With the exception of emergency situations, all treatment requires informed, capable, voluntary consent.

- **INVOLUNTARY TREATMENT – INTERNATIONAL DEVELOPMENTS**

According to the UN Committee on the UN Convention on the Rights of the Disabled (UNCRD), and more recently the WHO, it is the right to refuse treatment that should be prioritized. They have taken the position that the UNCRC means everyone with a disability, including those with a mental disorder, is deemed to have capacity to make treatment decisions and that involuntary treatment is always wrong and a violation of rights

There is a tension between society's duty to protect vulnerable people suffering from mental health and/or substance use disorders and an individual's human right to autonomy and self-determination

- **INVOLUNTARY TREATMENT – WHAT IS BROKEN**

Given the above, as caregivers, we are concerned that involuntary status determination will continue to put those we care for at risk if it fails to acknowledge that persons living with with mental health and/or substance use disorders may lack, because of their condition at some critical points in time, the ability to make decisions regarding their need for health care.

If we start with common ground that society does not want to see those living with mental illness and/or substance use disorders be incarcerated, homeless or die, and work backwards from there, it is easier to see what is required to achieve that result

Furthermore, if as caregivers we are not included in the discussions when the determination is being made there is also the risk that decisions made regarding involuntary treatment will not be informed by relevant mental health information caregivers are prepared to share based on lived experience.

THE NEED FOR REFORM – A CALL TO ACTION

Our intent is to urge the Minister of Health and Long-Term Care to review current legislation, practice and methods related to involuntary status determination and more specifically consider the following:

- **BEST PRACTICES – CONSENT AND CAPACITY**

- **Relevant legislation: Personnel Health Information Protection Act, Health Care Consent Act**

  - Publishing best practices and guidelines for how capacity should be evaluated in Ontario and ensure relevant legislation is accessible and understood

  - Providing direction and interpretation of existing legislation clarifying that the collection of personal health information in relation to involuntary status determinations under the *Mental Health Act* does not violate PHIPA.

  - Legislative changes to the Health Care Consent Act, Treatment Pending Appeal to provide for the timely processing of Ontario Consent and Capacity Board decisions under appeal

- **MAKING INFORMED DECISIONS – INVOLUNTARY STATUS DETERMINATION**

- **Relevant legislation: Mental Health Act**

  - Providing for clarity and assurances to health care providers involved in Form 1 determination - a physician may collect personal health information from individuals who are not health information custodians, including family members of the person, without consent of the person. Such collection is not a conflict with the *Personal Health Information Protection Act, 2004*."

  - Improving Form 2 process and communications between and among parties involved to ensure that the correct information is shared with police officers who are presented with the Form 2, and attending physicians making determinations about involuntary status during the examination.

- **LACK OF AUTONOMY**

- **Relevant legislation: Mental Health Act**

  - A broader definition of "Harm to oneself and others" to include psychiatric deterioration and inability to meet basic survival needs.

  - Acknowledging persons with addictions and/or mental health conditions often lack autonomy – for example, anosognosia causes many people with mental illness to refuse treatment as does the inability of persons with SUD to understand that their substance use is problematic.

  - Medical and legal standing for anosognosia with respect to SMI patients. This may include measurements of cognitive status that include evaluation of functions such as judgement and reasoning

  - **CIRCLE OF CARE**

- **Relevant legislation: Personnel Health Information Protection Act**

- Formally involving caregivers in the "Circle of Care" designated as allied caregivers and informal health information custodians; particularly with respect to informing forms 1 and 2 determinations as well as Consent and Capacity Board decisions including the timely processing of decisions under appeal

CONCLUSION

The issues around involuntary treatment are not easily addressed and there are likely more questions than there are answers. However, given what is at stake, we believe all concerned need to continue the dialogue.

As caregivers we need to seek opportunities to share our concerns as a caregiver community with the Ministry of Health and Long-Term Care.

To get things started, consider joining us and our community partners by sharing your thoughts regarding how best to effect the change required while both protecting vulnerable people suffering from mental health and/or substance use disorders and an individual's human right to autonomy and self-determination.

SEND US YOUR COMMENTS – at mailto:mica_ottawa@rogers.com