FRONTLINE PERSPECTIVES

Invited Submission

The Crossroads Chronicles

Set in the fictional Canadian city of Crossroads, Saskatchewan, with a population of 100,000 people, this feature follows the work of the Ethics Committee of a community mental health organization (CMHO) that provides services within a larger catchment area of 500,000. The Ethics Committee is made up of 12 members, with 6 being from the CMHO and six being from the community. Membership includes an ethicist, psychiatrist, nurse, social worker, minister, and case worker, among others. The committee is advisory to the CEO of the CMHO, who participates in the meetings in an ex-officio capacity. The cases, reflections, and reports are all real. The content has been modified to protect identities and maintain anonymity. More reports will be added from time to time.

1. Contraband Policy

Context:

- There is currently no contraband policy at the Crisis Shelter.
- Policy is needed for newer staff; existing staff tend to know what the practice has been.
- Contraband refers to any property that is illegal to posses under the Criminal Code of Canada (e.g. weapons, drugs).
- While not a lot of contraband comes into this program, it is important to have a process in place.
- Review of belongings happens upon admission to the Crisis Shelter.
- If any contraband is found, the client is informed they will have to remove it from the site before admission, or have it locked up at the shelter until their discharge.
- If they decide to take it off property and hide it, it is their right to do so.

Ethical Question:

- The ethical dilemma is at what point would police become involved? For example, if they came in with a gun, would we report it to the police or just ask them to take it off property? What is our moral and legal obligation with regards to community safety versus clients' right to their personal illegal property?

Discussion:

- Would we allow them to take it off property and store in the bushes or should police be involved?
- If they store something in the bushes or in a tree nearby, there is a degree of accessibility and potential danger (e.g. they could step outside if angry and access it).
- Potential to access provides a higher degree of risk to safety.
- If they say "no" to a lock box, then their option is to say no to their admission to the program.

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- What would be the threshold to report to police? Safety? What if it was a weapon used in a crime?
- Different staff would have different levels of gun safety knowledge (is it loaded?); even transferring a weapon from the client to the lockbox could pose some danger.
- Perhaps we should avoid locking up any weapon, because a threshold for safety would be ambiguous.
- Would we be able to support our client in problem-solving a safe place to put the contraband (not that we would actually do it but we would at least have a plan to mitigate the risk)?
- If so, are we aiding and abetting a criminal act?
- At a certain psychiatric hospital, clients tend to hide their stuff near a rock surrounded by trees.
- Our local hospital is surrounded by homes and a school.
- We do not want our efforts to preserve staff safety to put the community at risk.

Ethical Reflection:

The ethical stance of the worker at the door of the Crisis Shelter, at the time of admission, embodies an ethical dilemma for the organization as a whole. We are bound by confidentiality and at the same time obliged to promote community safety, and also at the same time respecting client choices and rights, and once more at the same time obliged to abstain from complicity in criminal activity.

Where do we draw the line?

The organization acknowledges and respects that clients will choose to live at risk and commit illegal acts. Our encouragement to the C.E.O. is to maintain this respect as long as our staff and the community's safety are not imminently threatened. Further, we advise the organization to protect our staff from complicity in criminal acts. However, staff are encouraged to use their discretion in consultation with their supervisor or manager on-call.

Recommendation:

Safety trumps privacy when risk is imminent; duty to protect privacy suddenly becomes a duty to warn.

In applying this principle to the presenting situation at the Crisis Shelter, it is recommended that staff do not lock up contraband or assist clients in removing contraband from the property. Instead, inform clients during the mobile assessment, out in the community that: 1. Contraband is not permitted on the property of the Crisis Shelter 2. We respect confidentiality and will not report a criminal possession unless there is imminent risk, 3. We will not support but will respect the client's need to make other arrangements before attending for admission to the program.

Staff can call the manager on-call if the process of removing the contraband would cause the client undue hardship and the contraband is considered minimal and of no risk to others by its presence (e.g. a bag of cocaine). The on-call manager will assist direct service staff in making a judgment call, weighing out the inherent risks of the contraband and mitigating factors of the proposed solution. For

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example, flushing or locking up a gram of marijuana in comparison to locking up a 5-inch blade.

2. Pet Care and Reporting Cruelty to Animals

Context:

- Mental Health Supportive Housing program staff attended a presentation with a hoarding specialist, who had spoken about animal hoarding and how he has come across neglect and cruelty to animals. As he is hired as a support person he is not able to report to the Society for the Prevention of Cruelty to Animals (SPCA) or Humane Society because it is breaching the Personal Health Information Protection Act – they become his clients.
- A Housing Worker from the CMHO is looking for the agency to make a statement on where we stand with regard to reporting observed cruelty to animals.

Ethical Question:

- Are CMHO staff in a position where they would report cruelty to animals, or is this breaking our trust with the clients we support?

Discussion:

- Are these animals at imminent risk of suffering? It would depend on the situation.
- If there are dead animals or feces, this would affect the well-being of the client.
- This is a multi-pronged problem – what is the effect of the improper care of these animals on the client? What about legislation, and the issue of disease?
- How is this affecting the client?
- If we report, we may break rapport.
- This has happened once before in one of our group homes where a client injured a cat and the police were called under the Mental Health Act; other clients at the home followed-up with the police because they were disturbed and the client was charged.
- Criminal acts are not a reason to breach PHIPA – which ties our hands.
- The worker could, however, counsel someone else to call – for example, if the landlord initially identified the problem then the landlord could be encouraged to call the Humane Society. If the landlord was not aware, the worker could call the landlord and say “are you aware of the 17 cats that are living in the home” and let them know we are concerned.
- Does imminent danger only apply to human beings? Would this agency apply it to animals?
- Another layer – a tenant was pregnant and the home was problematic with cat waste, which we reported to Children’s Aid (which fell under risk to a child).

Ethical Reflection:

- After discussion, a value promoted by the Ethics Committee is that animal suffering is, in and of itself, unacceptable and has implications for the mental wellness of our clients and staff.

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- With consensus, the Ethics Committee offers the C.E.O. the suggestion that occurrences of serious harm or neglect towards pets of clients be designated as reportable to appropriate authorities, ideally with client consent but not requiring client consent.
- With regard to rapport, clients may not always appreciate our actions. It does not necessarily destroy the rapport in the long run, and in fact can improve it in the long run.

Recommendation:

- Harm to animals would be reportable to the SPCA rather than the police because our concern is for the safety of the animal more so than the legality of the client behaviour.
- Language along these lines could be developed for the agency service agreement.
- In situations that are not imminent, creative avenues respectful of confidentiality should be sought for aid to the animals, e.g. working with the landlord, family members, friends.
- Another option is to call in the Housing Admin staff to ask them to discuss matters of concern with clients, and the program can make purchases to help (e.g. a litter box).
- It would be good to call the Information and Privacy Commission to see what their stance would be on this matter? Would animal cruelty, and imminent risk of harm to animals, be considered an inappropriate breach of confidentiality laws?
- Take this to the CMHO Privacy and Security committee for action; they need a sign-off from privacy commissioner before finalizing this approach, and if approved then put it in the CMHO service agreement and the reporting guidelines policy.

3. The Right to Go Home

Context provided by staff:

“A 27-year-old male client lives in a CMHO apartment on a lower level with a fire escape window just below ground level. The client chose to have elective foot surgery and following the surgery he had a plaster cast and was informed that he could not bear weight on that foot for a minimum of 2 weeks. As the client is usually unsteady on his feet he did not wish to have crutches but would use a wheel chair for mobility.

The client wished to return to his apartment following the surgery so the staff took him home to test whether he was able to exit his apartment safely in case of an emergency. To get down the stairs, the client held both hand rails and raised the foot in the air and hopped on his other foot; it took him a couple of minutes but he got down safely and he paused to rest on the landing between stairs. In the apartment he used a wheel chair to get around. Staff rearranged the furniture in his bedroom so he had easier access to the window and he wheeled himself in and attempted to climb out the window; at first, he could not get up and continued to attempt but was not able to manoeuver out. The client rested and attempted again and was unsuccessful.

A Health and Safety Representative, a Manager, and a staff determined that he was not safe to be in the apartment as he could not safely get out in an emergency. After much discussion, it was

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decided that the client would stay in a hotel over night for 1 week and return to his apartment during the day to do the things he wanted and to practice getting out of his apartment safely. The client still expressed his wish to stay in his apartment but agreed to stay in the hotel for the week. During the week at the hotel staff picked the client up in the morning and assisted him in returning to his apartment and with daily activities and practicing climbing out the escape window. After the week the client was comfortable getting in and out of the window and returned to his apartment."

Ethical Question:

"The ethical part of this scenario is that the client wanted to go home (his choice) and we would not let him because we thought it was unsafe."

Discussion:

- Discussion revealed additional context: this client resides in a CMHO owned residence, not a free market apartment in the community. Understandably, this raises the expectations of staff and supervisors on the level of responsibility assumed by the agency for a client's safety regardless of their choices.
- This became awkward once the client was forced to stay in the hotel. We took away their freedom to choose which the committee felt upon reflection was unethical.
- A more ethical stance was proposed which would be more proactive and preventative, and less reactive and contravening of client wishes.

Ethical Reflection

- In this case, the Ethics Committee felt that duty to care is a serious and understandable concern but is outweighed by the autonomy and freewill of the client. The duty to care is best when used as a motivator to mitigate risk through proactive strategies in collaboration with the client and supporting them to make an informed decision.

4. <u>Online Wellness Toolkit</u>

Context provided by staff (presented by a Peer Support Worker and the manager of the Communications Department):

"Attached is the wellness tools list that has been put together by WRAP and Wellness Group members. The WRAP program is an evidence based program developed by and for people with lived experience. A key component in the group is to develop a list of wellness/coping tools. It has been requested by a group of persons receiving services at CMHO that CMHO brand this document and use it as a handout or possibly upload it on the website as a resource for people who may be looking for support in coping.

Peer Support staff submitted the list to the CMHO communications department to brand and post on the agency website. Communications staff advised peer staff that some of the wellness/coping tools would have to be omitted from the list. The suggested omissions included alcohol, cigarettes, sex, taking medication, and prayer. It was also noted that bubble baths, changing clothes, and

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rearranging furniture may or may not be OK because people may have limited clothing, may be homeless, etc. Alternatively, it had been suggested that the document be branded ‘as is’ with the inclusion of a disclaimer. The disclaimer would explain that: “All wellness tools, if used in moderation, can have a positive result, whereas wellness tools used in excess can have a negative impact on wellness. The items on this list may not be suitable for every individual in supporting their recovery. When choosing a wellness tool, it is recommended that you consider the effect that the wellness tool will have on your recovery and only to proceed with a particular strategy if it is going to have a positive impact on the recovery process.”

Ethical Question:

“The questions raised are: Are we stigmatizing people with lived experience if we do omit their wellness tools? (Assuming all people with lived experience have alcohol misuse issues, sex addictions, are poverty-stricken, etc.) Or can we leave the document as is and include a disclaimer? Please review the attached document of wellness tools developed by the WRAP and Wellness Group Members”.

Discussion:

- How does your WRAP group define wellness? As being able to live a good life...symptoms of mental illness can impact one’s ability to live a self-directed life, but health does not necessarily mean wellness.
- Are wellness, recovery, and health considered separately?
- Is this used in group and one-to-one? Both.
- Once this is a branded document, even with a disclaimer, it could become an enabler, and even a liability concern.
- What harm would come to those individuals if we edited the list? Did we tell them we are looking at it? Answer: “Yes, they are happy we are looking at the tool and want to be able to help others and appreciate this feedback.”
- It was proposed that we review other lists, that we vet ours in comparison with others, and that we put an introduction on it explaining where it came from (clients’ brainstorming session).
- Then the suggestion was made to give it back to the WRAP group to edit out for health and liability (e.g. considering alcohol and cigarettes as some of the options that are highly volatile/triggering/potentially unhealthy/capable of misinterpretation).
- The Ethics Committee offered to review the newly revised list if the WRAP group considered it to be helpful.
- Communications suggested that they may further edit it before putting it on the agency website.

Ethical Reflection:

- On one hand, from an ethical standpoint, one inclusive list of wellness tools should be considered appropriate for anyone to read and consider without assumptions or stigma about who is reading it. On the other hand, omissions that presume anything about the reader’s life

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situation and mental health status would be stigmatizing for those who are aware of the act of omission. On the other hand, anyone who receives the final edited version (who did not see the original document) could be in a better position to use the list without feeling stigmatized.

Recommendation:

- The agreed upon actions were for the Peer Worker to discuss the list with the current WRAP group and for the Communications staff in consultation with the Peer Worker to then finalize the list before branding and posting.

5. No Trespass Order

Context provided by staff:

"A CMHO Health and Safety Representative and a Community Support Worker had gone to an apartment for a bed bug inspection. When they entered the apartment there were the client, her boyfriend, and another couple sleeping on the floor. The apartment was very dirty and the client was prompted that she needs to maintain more cleanliness in the apartment. The couple are a known street worker and her pimp boyfriend. There have been needles found lying around the client's apartment as they are drug users. The boyfriend became mad after everyone left because of how dirty the apartment was and he said the client does not do any cleaning. This is when the fight began. He was verbally aggressive and over-turned her coffee table and broke a bookcase in anger. A No Trespass Order was subsequently put in place by CMHO and the landlord at the client's request. The written Order was posted on her door and given to the police. They quickly reconciled (within a day or two) and now the client would like the Trespass Order lifted."

Ethical Question:

We have not supported the client to have the Trespass Order lifted yet due to complexities of the situation (outlined in the discussion below). However, do any of these issues factor in? If she wants it lifted, do we lift it?

Discussion:

- Reasons for concerns include this client's vulnerabilities.
- This young woman has a diagnosis of Mild Intellectual Disability, Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), Post-Traumatic Stress Disorder (PTSD), and possibly Fetal Alcohol Spectrum Disorder (FASD).
- She has Type 1 diabetes – insulin dependant and uses a Ping Pump. She should be testing her blood sugars 4-6 times daily and using insulin for all carbohydrates eaten.
- Her trauma history is significant. She was abused by a trusted male in her youth.
- She has significant cognitive limitations and requires supports that are consistent and repetitive.
- She has limitations in social and emotional maturity.

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- She had a Capacity Assessment for finances done several years ago and a government trustee has managed her finances since.
- CMHO receives special funding that provides up to 19 hours of support weekly.
- She requires support to manage her diabetes. It had been challenging to support her with this when she was living on her own; however, when the boyfriend was living with her it became more difficult as staff were not spending as much time with her in her apartment. That being said, her overall health has not changed – blood sugars remain high but with no increased health risks.
- She requires ongoing support with most Activities of Daily Living (ADLs). Maintaining her apartment is a significant area where staff have needed to be in her apartment most days to support cleaning. When the boyfriend was living there, it had been challenging to provide her required supports in home as he was often there, sleeping or sitting on the couch but not participating. It seemed to be their expectation that staff would come and clean up “for” them.
- She receives help with building interpersonal and intrapersonal skills. Support includes help with problem solving, decision making, assertiveness, conflict resolution, knowing yourself, emotions, self-confidence, responsibility, dealing with stress, and making healthy and safe relationship choices.
- The client has discussed concerns with how her boyfriend has spoken to her in the past: “He calls me ‘retard, stupid, idiot’ when upset with me”.
- The boyfriend has been to jail on assault charges related to a previous girlfriend. He and the client both deny any wrong-doing, saying that the “ex-girlfriend lied”.
- She has difficulty saying no to anyone. Often other people come into her apartment to couch surf (occurring with and without her boyfriend present).
- The client had her boyfriend move in with her several months ago and did not go through her landlord to add someone else to Lease. A rent subsidy is in place through CMHO but it is not a CMHO building. Her boyfriend had not wanted to inform her financial trustee or the disability payment office about his presence. He collects welfare and has not declared that he is no longer at his previous room; he is collecting the full welfare amount (fraud) rather than the shared living amount, and he is not contributing to rent. There has been an ongoing discussion among her support team and Housing staff – they have not pursued adding him to the Lease even before the incident due to the complexities and concerns.
- The landlord does not like him and would prefer that he not come back; however, the Housing program has said that they can work through this issue with the landlord.
- The client and her boyfriend both say that if he can come back into the apartment they are willing to inform the welfare and disability offices, and they know the rent will then be increased. This would make the landlord happier with the situation as he would get the increased rent.
- She has stated that she would “rather be homeless than have him not live with her”. Prior to her boyfriend moving in with her she often stayed with him at his rooming house. This was an unsafe setting. It is very possible that if he does not move back in with her, she will choose to follow him wherever he moves and then be in potentially worse unsafe situations.
- She has a right to choose to live at risk and still get CMHO support for community inclusion as well as support with meeting her health and safety needs.

Ethical Reflection: Ongoing support for healthy activities of daily living may be helpful, as is counselling and psychoeducation regarding safe and healthy relationships. Going against the will

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and decision making of this client in the absence of imminent risk to self or others is understandable due to the care and concern staff feel for the client, but this would not be considered ethical in terms of respect for her autonomy and freedom to make choices, including choices that may increase risks of harm in her situation.

Recommendation: Focus on respectful positive intensive support and guidance to influence the decisions this client is making from day to day.

6. Consent and Capacity

Context brought forward by a Dual Diagnosis Worker and Crisis Program Manager:

"Concern: To explore the ethics around consent and capacity for individuals who are of legal age and who have a cognitive impairment and/or dual diagnosis. This context is primarily focused around two broad scenarios:

i. Individuals who are signing and acting on their own behalf but where consent and capacity is questionable or being influenced heavily by a caregiver or service provider.
ii. Caregivers or service providers are signing or acting on behalf of a client without formal legal authority to do so."

"Case: BL, a 24-year-old with autism and developmental disability recently came to the program via Developmental Services Saskatchewan. BL's mother was acting on behalf of her son in all decision making capacities, including signing of consents and service requests, without legal consent to do so. When asked, mother expressed frustration as this has "always been the way". The mother refused to include her son in any of the decision making and consent processes required by this writer to engage in services. Mother communicated that she had been acting on her son's behalf "his whole life", did not wish to pursue the cost of formalizing herself as substitute decision maker, and felt that she did not wish to "start a precedent" of having her son "put mark to paper" as she did not believe her son could make decisions on his own behalf. As a result, this writer had to close the file. "

Ethical Question:

How can we, as service providers, work within a flexible framework to support a particular vulnerable population without impacting client access to service and compromising legal requirements in place around consent and capacity?

Discussion:

- Lengthy discussion of the circumstances included the recognition that the mother clearly does not have power of attorney and that the son is signing without confirmed capacity to do so.
- Disability services and authorities were consulted, and they did advise respecting this Mother's signing authority.

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- The group then challenged how that direction and leaning of the Dual Diagnosis service system conflicts with Consent and Capacity legislation and the agency's own policies and procedures for consent, which did not appear to be followed in this case.
- In the absence of clear direction, the worker felt obliged (against her desire to help the mother and son) to close the file in order to maintain compliance with legislation and agency protocols

Ethical Reflection:

- Key factors in reaching consensus on this ethical reflection were: 1) the presence or absence of coercion, and the worker was of the opinion there was no coercion in this case; and 2) consent and implied consent.
- An ethicist put forward the suggestion that implied consent was present and gave a clear endorsement of the practices of the mother and the care providers in this case.
- A third consideration is that this is a well established norm in the Dual Diagnosis sector, and that families informally have acted as decision-makers and signatory authorities for many years. This permission and support for families is essential in order to maintain a barrier free service for dual diagnosis individuals and their families.
- One major barrier identified in this discussion was that the large fee for capacity hearings (approximately $5,000), is a major impediment for family members who might wish to assume the substitute decision making (SDM) role in accord with legislation.

Recommendation:

It was recommended that the CMHO Dual Diagnosis Workers could respect the assumed SDM and signing authority of family members as long as they were not being coercive, were acting with best intentions, and in the best interests of the client.

7. Complicity with, or Support for, a Client Living at Risk?

Context:

The Dual Diagnosis (DD) program team is supporting an individual with a medical history of Diabetes, Heart Disease, Hypertension, Chronic Obstructive Pulmonary Disease (COPD), Obesity, and Schizophrenia. His treatment team includes Dual Diagnosis Case Management staff, a Group Home Residence, Family Doctor, respirologist, cardiologist, Community Nursing Service, a Medical Devices Company, a Diabetes Clinic, and a psychiatrist.

This individual is quite articulate and is deemed capable of making his own treatment decisions. His ability to articulate well may mask cognitive challenges in many areas (such as follow through, i.e. he can "say" what needs to be done but he does not do it – he wears a cloak of apparent competence). There is a long history of this individual not following the advice of health professionals. All attempts, both past and present, at encouraging him to take responsibility for his

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own health have proven unsuccessful.

He has been advised by health professionals that he must lose weight as this is affecting his lung and heart functioning. He has been receiving oxygen at night through his Bilevel Positive Airway Pressure (BiPAP) machine and has now been advised that his oxygen levels are at the point where he requires oxygen during the day, particularly when he is exerting himself.

The client has stated that he, “will not use daytime oxygen, it is my life and if I choose not to use daytime oxygen and die, it is my business and nobody else’s”.

DD Program staff and the client have been trained on daytime oxygen use and the required equipment is in his apartment. He has used oxygen once while grocery shopping and noted the improvement, i.e. he did not feel out of breath. However, since this time he has refused to use oxygen while grocery shopping. He does sometimes use daytime oxygen while watching T.V. in his apartment but staff report this usage to be very minimal in spite of his claims of frequent use.

At present, this client is not exercising or adhering to a healthy diet. At an appointment with his Family Doctor last week his doctor explained to him the risk of sudden death due to the strain on his heart. He indicated that he understood the risk he is taking by not following medical advice.

DD Staff have noted that when they support this man with grocery shopping, he gets out of breath and there is great fear that he will “drop dead”. There is concern that supporting this individual with grocery shopping without his oxygen is in fact facilitating a high risk, potentially fatal, activity.

It is for this reason, staff are considering placing a condition on support with grocery shopping, namely that he must utilize his oxygen.

Ethical Question:

Is it ethical to refuse certain support services if an individual does not adhere to a doctor's recommendation and puts his life at risk?

Discussion:

- The individual is able to grocery shop independently and only relies on staff for transportation. He also relies on peers at his residence for assistance by paying them cash to run errands for him.
- He chooses not to utilize bus services. He uses a taxi to go to a restaurant for meals and has the funds to exercise this option, as he has a trust fund managed by his brother.
- Would we be having this conversation if this individual did not live at a group home in a supported living environment? If this individual lived in their own apartment in the community, would we look at this situation differently?
- Is it ethical to support an individual in an activity where they place themselves at unnecessary risk?
- Could we equate this situation to taking a client out in a boat after they decide not to use a life jacket?

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- In CMHO agency documentation it says that clients have the "right to choose to live at risk, to have others involved in my service as I choose, to participate in all aspects of my service and make personal choices based on informed decisions, to disagree with service recommendations, and to receive safe, competent services".
- Over the course of this detailed discussion, the emphasis gradually shifted from considerations regarding the client's choices to an awareness of the staff's feelings of responsibility and ownership for the client's risk. This became very apparent when the staff person stated in reference to the client possibly dying, "this won't happen on my watch", and the emotion that accompanied this statement.
- Not surprisingly, discussion highlighted the deep feelings of concern and responsibility for clients' survival that team members have, rooted in a strong ethical commitment to caring for highly vulnerable individuals over extensive periods of time.
- This emotional burden was acknowledged and the ethics committee commended the team for its passionate caring and commitment. That said, it was made clear that in spite of one's best efforts to care for clients, clients may still choose to live at risk in a way which could ultimately lead to their harm or demise.
- The staff members present expressed their relief with the decision and the permission to let capable clients make their own poor health decisions. They said other team members would also feel relief when they hear the outcome of the discussion.

Ethical Reflection:

- Our ethical obligation to clients is to fulfill our duties and do our best, but at the same time to respect a client's right to live at risk and make choices that put themselves in harm's way. While the emotional concern this raises for staff is understandable, it does not necessitate actual assumption of responsibility for choices that clients make. It can even be help the relationship when staff fully recognize and allow for the client's freedom to choose to live at risk.

Recommendation:

- Provide in-service training/support for the DD team regarding caregiver stress, compassion fatigue, and vicarious trauma. (This training was provided in two follow-up sessions to the DD team who expressed gratitude and recognized the importance of the professional development made possible by this process.)
- Further staff education related to ongoing issues in this case focused on anticipatory grieving.

8. <u>Third Party Referral to Help Someone Who is Not Help-Seeking</u>

Context:

CMHO services are voluntary, respecting the right "To choose to live at risk" and "To refuse service" (according to our "Rights and Responsibilities" documentation).

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The Crisis Program participates in a “Risk at Home Coalition” made up of many community partners to serve people in their homes who are at high risk for further mental, medical, and psychosocial deterioration, resulting in 911 calls, visits from emergency medical services (EMS), Police, Fire Department, or other First Responders.

First Responders are frequently attending in homes where hoarding, hygiene, substance use, poverty and many other social determinants of physical and mental health are creating high risk situations. The Risk at Home Coalition identifies three levels of risk, with three potential pathways to help for these individuals.

1. Emergency levels of risk require direct and possibly involuntary intervention such as involuntary committal (detention under the Mental Health Act), or an ambulance trip to the emergency room (ER).

2. Urgent levels of risk, constituting a crisis but not requiring a 911 response, require a referral to the Crisis Team to coordinate an in-home collaborative mobile visit. Referrals are sent directly to the Crisis Program by Emergency Services, Police, Fire Department or other responders.

3. Non-urgent (but still high risk situations) result in referrals to the Home Care Service Agency for a non-urgent response, so that they can organize a collaborative response within 2 weeks.

The target population for the Risk at Home Coalition are people living and suffering in substandard and high risk conditions who need help but are not seeking help for a variety of possible reasons, such as judgement impaired by mental illness or substance abuse, long-term adaptation to very difficult circumstances, or sheer hopelessness.

Ethical Questions:

- What is our ethical response to third party referrals for persons at significant risk who are not themselves seeking help?
- How do we respond in a manner that is helpful, assisting with crisis response and intervention, and also respecting the right to refuse treatment?
- Should an agency or society proactively help people who can seek help but are not seeking help?

Discussion:

- Discussion initially focused on the complex needs of persons living in hoarding situations who may be unaware of the environmental and personal health risks.
- The absence of help-seeking behavior was considered key to this discussion.
- The Crisis Program does not regularly respond to third party referrals in the absence of indicators of help-seeking.

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- Before a determination could be made as to the ethical implications of this question, the question of program policy was raised: simply put, does the program accept and respond to third party referrals? Yes or no?
- Regardless of the ethical implications of the treatment needs of complex individuals who are not seeking help, clarity is required on the part of service providers from a policy and procedure standpoint.

Ethical Reflection:

- The Crisis Program was asked to review and clarify its own policy, protocol, and practice with respect to third party referrals.

Recommendation:

- There is no ethical recommendation since this is deemed to be more a question of program policy.

Date of Publication: May 23, 2018

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