

## Achieving Ethical Mental Health Practices

Despite the constant influx of new ways of looking at both traditional and non-traditional perspectives, and the emergence of an ever-growing field of research, it is often difficult to develop a true appreciation for innovative ethical mental health practices. Then there is the challenge of knowing whether the innovative approaches are readily adaptable to your practice and your environment. Put another way, we seem to want to know “what’s new”, “what’s next” and “what’s a better way?”

But there are other questions, so many questions, that frame our thinking and help us sort through the varied and sometimes mysterious processes that often cloud the way. For example, what value do we put on ethical mental health practices? How should we examine what we do in a way that puts ethics front and centre? Can we assume that effectively applied ethical mental health principles will result in better clinical outcomes? How do we provide meaningful leadership and facilitate the transition to an environment in which ethical mental health practices are the norm and not the exception? How do clients/consumers and their families view ethical mental health practices? And the list continues.

But one question deserves special attention. How do we best learn and teach ethical practices in the mental health field?

Of course, there are many ways available for us to learn about ethical practices in mental health ranging from reading a journal article or book, to hearing a lecture, to attending a conference, to consulting an eminent expert, to accessing a good coach, to observing best practices in action, to participating in an on-line forum, to watching the latest episode of a medical drama on TV, and so on. All are legitimate ways of building one’s repertoire, knowledge and experience.

The critical factors in any method of learning or teaching mental health ethical practices should be to: enliven the openness of the debate and discussion; to stimulate the ethical analysis; to fully explore the attitudes and values underlying the issue; to transport the issue from

the theoretical to the practical; to heighten ethical sensitivity and awareness; to engage the client/consumer and his/her family in a meaningful way; to position ethics as fundamental to clinical decisions and practice; and to facilitate ethical action.

There are encouraging signs that these critical factors are becoming more prominent, more scientific and more common place. It is hard to envision what the future shape of ethical mental health practices will be and how quickly it will unfold. Suffice it to say the path is clear, all signals are green and there is no turning back.

The current issue of JEMH offers a broad array of invited and peer reviewed submissions for your consideration in the Articles, Frontline Perspectives and Benchmark sections. This is complemented by articles in the In My Life and Insight sections and a review in the Book Review Section.

The next issue of JEMH, in April 2009, will feature ethical considerations and the pharmaceutical industry. Dr. Richard Warner will be the guest editor. He is Professor of Psychiatry and Adjunct Professor of Anthropology at the University of Colorado. The publication will examine key ethical issues that are raised by the role, structure and business practices of the pharmaceutical industry and will identify strategies that speak to the challenges facing mental health practitioners, policy makers, clients/consumers and their families.

As always we are pleased to hear from you. Please send us your comments and your suggestions. In the meantime, enjoy your read of this issue of JEMH. May it cultivate and stimulate your practice and reinforce your leadership in and commitment to the field of ethics in mental health. her developments related to the Journal of Ethics in Mental Health.

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## By What Authority? Conflicts of Interest in Professional Ethics

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### I. Does the Ethical Emperor have Clothes?

Paradoxically, the profession whose primary mandate is to instruct and comment on matters of ethics spends inordinately little time reflecting on its own ethical practices. Consider the fact that while professional ethicists of all stripes crusade to expose and denounce conflicts of interests in all other branches of the health care system, they typically fail to pay much attention to their own potential 'ethical' conflicts of interest. Admittedly, there have been some efforts to address the problem. However, despite laudable intentions, they are highly unsatisfactory. Unenforceable 'model' draft codes of ethics on professional websites,<sup>1</sup> and obscure addenda to technical reports that are only available at a cost,<sup>2</sup> do not constitute acceptable responses to this predicament. This is a problem of profound social importance, a matter that threatens the very foundation, integrity and accountability of one of the most powerful forces in the modern health care system.

There is of course an expectation that, like other health care professionals, ethicists should abide by and declare all potential or actual conflicts of interest. But the point is that professional ethicists are subject to special conflicts of interest that are not covered by traditional guidelines and regulations. These conflicts arise directly from their professional mandate, which is to provide ethical expertise and advice. It is surprising that these special 'ethical' conflicts of interest in professional ethics attract so little attention. Neither professional ethicists nor those they serve seem very concerned. It is time we pay more attention to these potential 'ethical' abuses and risks of the ethics profession. This problem appears to be another case of the proverbial 'elephant in the room'. Everyone knows there is a problem, and a big one. But everyone pretends not to notice. To use another memorable metaphor, this may well be a case where the ethical emperor has no clothes!

### II. Why Conflicts of Interest are Ethically Objectionable

Most health care professions have codes of ethics or conduct that are meant to govern the behavior of their members. Those codes usually have explicit provisions that address conflicts of interest that are specific to the practice of that profession. What counts as a conflict of interest varies across professions, as do sanctions and disciplinary measures. The nature of conflicts also varies. Some revolve around abuses of power or other kinds of inequalities. Some involve money or other financial interests and incentives. Nonetheless, despite these different varieties of conflicts and interests, it is still possible to venture some general remarks as to why conflicts of interest are thought to be ethically objectionable.

Consider the fact that most health care providers are usually not allowed to accept personal financial gifts from their patients. Nor are clinicians supposed to favor and recommend therapies or products because they stand to benefit from them. Many medical journals and research organizations now have provisions to protect against conflicts of interest. It is now widely accepted that clinical researchers engaged in testing and evaluating pharmacological agents must declare any financial ties or other obligations they have to the companies that produce and market those products.<sup>3</sup>

In many cases, it is the fact that interests are disguised or kept hidden that is thought to be ethically objectionable. Thus one reason why conflicts of interest are thought to be ethically objectionable is that they often introduce a hidden or disguised bias in the recommendation or provision of a product or service. This is not the only reason why conflicts of interest are thought to be ethically objectionable. But it is an important one. The worry is that such hidden biases do not serve the interests of consumers. Instead, they serve the interests of the persons, institutions, or industries, that provide the products or services in question.

So what is often thought to be especially ethically pernicious about conflicts of interest is the fact that they are hidden or disguised. Once a conflict has been exposed or declared it may still constitute a conflict. However, ethically at least, it has been attenuated in an important way. Consumers can then sometimes make a fairer and more informed decision, or simply abstain. At minimum, everyone involved is now aware that there is a conflict. Note that even the perception of conflict is often enough to require remedial measures. Here as well, when a conflict is declared or exposed, ethical worries are sometimes attenuated. At least the fact that there is a conflict has been rendered transparent for all to see.

### III. Ethical Conflicts and Interests in Professional Ethics

What then are the special 'ethical' conflicts of interest that threaten the ethics of professional ethics? A preliminary analysis suggests that they may occur on a variety of levels, ranging from ethics education, clinical ethical consultations, and special ethical advisory boards and committees.

#### *Ethics Education*

Ethical education in health care contexts requires the deployment of ethical expertise. That requires a knowledge of ethics and ethi-

cal assumptions. Such assumptions are often innocent enough; for example, explaining what a given ethical code or guideline says, describing relevant ethical precedents surrounding a case, or simply examining a situation from the point of view of different ethical theories. All of this can be done more or less 'objectively,' let us grant. The problem is that in practice ethics education is not always so ethically innocent. In difficult and problematic cases, the manner in which one 'describes' a case usually involves important assumptions that invariably accompany the use of technical terms and explanatory notions. The 'facts' that are thought to be relevant are not usually simply out there, ready to be described, but rather actively selected from a variety of possible alternate descriptions.

So even at this ostensibly 'objective' level of ethical practice – ethical education – the practice of professional ethics may be subject to ethical biases that inadvertently direct the audience one way rather than another. Admittedly, it may be hard to present an ethical case study intelligibly and at the same time question and criticize the terms used to 'describe' that case. It is as if one were asked to saw off the branch on which one is asking the audience to sit. No doubt, philosophical pundits will insist that impartiality and objectivity in ethics education may be dangerous myths of their own. This may very well be true at more highly refined levels of case presentation and philosophical analysis. However, it does not nullify the value of impartiality or objectivity as laudable philosophical goals at many levels of ethics education.

Note that in ethics education in religious health care institutions, conflicts of interest may actually be mandated by the employment contracts of professional ethicists. Specific ethical viewpoints are promoted in accordance with the religious mission of that institution. Though such conflicts are often transparent and openly known by all involved, they may constitute conflicts nonetheless. For example, they may be judged to be ethically pernicious by outsiders or dissatisfied insiders. Such mandated ethical directives may also extend to the provision of clinical services, which can impact directly on the provision of ethical services in clinical ethics consultations.

#### *Clinical Ethics Consultations*

Suppose that after discussing their case with a clinical ethics consultant and agreeing to withdraw life-sustaining treatment for a loved one, a family later discovers that the ethicist who advised them is an ardent supporter of euthanasia and assisted suicide. In an informal discussion with other patients in the waiting room, they discover that this particular ethicist has a reputation for always 'pushing' for withdrawal of treatment and not presenting alternative options fairly or at all. That would certainly be grounds to suspect an 'ethical' conflict of interest on the part of the ethicist in question. The problem is that professional ethics currently has no satisfactory means for addressing or redressing such clinical ethical conflicts of interest.

Clinical ethics consultations can also raise difficult issues of conscience. There can be cases where ethical conflicts exist between an ethicist's personal views and the ethical mandate or orientation of the institution they work for. In cases where certain procedures are simply not made available in a given institution, an ethicist may choose to refer patients to another institution. A variety of different ethical conflicts of interest may be at play in such circumstances.

Such issues raise difficult 'dilemmas' of their own. There can even be cases where patients may be consulted by ethicists representing different ethical interests. These can occur in large medical complexes that offer and combine services across different hospitals.

#### *Ethical Advisory Boards and Committees*

Consider now the conflicts of interest that may arise when professional ethicists are asked to provide ethical expertise or advice to boards and committees. Conflicts of interest of an ethical nature can also occur in this setting. Since these are settings where consumers and other professionals often expect impartial 'professional' advice from ethicists, it is extremely important that such conflicts be declared at the outset. The provision of such impartial ethical expertise and advice must be sharply distinguished from cases where ethicists are required or invited to express their own 'personal' ethical opinions. There is nothing necessarily ethically objectionable with the provision of such personal ethical advice, so long as it is not surreptitiously disguised as impartial professional advice intended to present ethical options without bias.

Suppose that unbeknownst to their fellow committee members, an ethicist has a vested interest in taking a specific ethical stance on a policy question. Perhaps this is because of a hidden personal ethical agenda. Or because they and some other party stand to gain from manipulating the outcomes of the committee or board towards a particular ethical end. It is hard to deny that such conflicts of interest may occur in professional ethics and that they are ethically objectionable. The possibility of ethical conflicts of interest on granting bodies and agencies is an especially important worry in this regard. Empirical research on conflicts of interest in other areas of the health care system has been revealing.<sup>3</sup> It is interesting to ponder what similar research might uncover in the area of professional ethics.

In response to these worries, it seems reasonable to suggest that ethicists who are being considered for advisory boards and committees should be compelled to declare any potential 'ethical' conflicts of interest of this sort *before* they are appointed, a suggestion that is likely to make many professional ethicists bristle.

#### **IV. Diagnosis and Tentative Suggestions**

One can only speculate why so little attention has been paid to the study and regulation of ethical conflicts of interest in professional ethics. Certainly the theoretical and practical difficulties involved in regulating the ethics of professional ethics are considerable. The question how exactly to distinguish legitimate personal ethical commitments from illegitimate personal ethical biases and agendas is sure to pose especially difficult challenges. So are the complex funding formulas according to which professional ethicists are sometimes remunerated in large institutions.

Making changes will be difficult. Professional ethics is already a thriving industry. To make changes we must rebuild the ship while keeping it afloat. One problem is that raising such issues might undermine the authority of the ethics profession. What, after all, gives anyone moral authority over the ethics of anyone else? There is therefore a risk that the ship might sink as we try and repair it. Or that it may drift aimlessly at the mercy of external forces. And let us not forget the politics of ethics. This is the problem of conflicting

ethical agendas, where different factions seek to impose their own vision of ethics on others. In the end, there is no escaping the fact that professional ethics is a profession whose own ethical house is woefully in need of order and scrutiny.

No doubt, many ethicists will balk at the suggestion that their professional activities might be morally tainted by their own undeclared or partisan ethical biases and agendas. Some may dismiss the suggestion that ethicists should be required to declare such conflicts with disdain and superiority. But ethicists are not ethically superior to anyone else in the health care system. Quite the contrary. Ethicists must be ethically accountable to those they serve. That means they must declare any ethical conflicts of interest they may have. And so, in the spirit of good faith, let me begin here, with my own tentative disclosure of ethical interests.

#### 'Model' Personal Declaration of Ethical Interests.

The present writer is a philosopher and former 'bioethics consultant' with a strong personal philosophical commitment to pragmatism in epistemology and anti-theory in ethics, as well as a strong skepticism about the philosophical credentials of 'bioethics'. The author is also a religious believer brought up in the Roman Catholic tradition, but one who no longer believes or adheres to many tenets of that faith. On the matter of specific ethical issues relating to health care, the present writer remains ethically open to the moral permissibility of the following medical interventions: abortion, euthanasia, assisted-suicide, the use of assisted reproductive techniques for gay couples, and properly administered safe injection sites for treatment refractory addicts.

#### Notes:

1. See for example the Model Draft Code of Ethics available on the website of the Canadian Bioethics Society at <http://www.bioethics.ca/draftcode.pdf>.
2. See for example 'Core Competencies For Health Care Ethics Consultation' posted on the site of the American Society for Bioethics and Humanities at <http://www.asbh.org/publications/core.html>.
3. Trudo Lemmens, Conflicts of Interest in Medical Research: Historical Developments. In Ezekiel Emanuel, Christine Grady, Robert A. Crouch, Reidar K Lie, Franklin G. Miller, and David Wendler (Eds.). *The Oxford Textbook of Clinical Research Ethics*, Oxford: Oxford University Press, 2008, pp.747-757.
4. *The View From Here: Bioethics and the Social Sciences*. Raymond De Vries, Leigh Turner, Kristina Orfali, & Charles Bosk (Eds.). Oxford: Blackwell Publishers, 2007.

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## A Commentary in Response to: By What Authority? Conflicts of Interest in Professional Ethics

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Note: the author of this commentary was blinded to Dr. Charland's identity.

Perhaps I am naïve when it comes to considering the role of ethicists in the sphere of health care but I cannot detect the reasons why the author of this article is so disconcerted as to refer to them as emperors without clothes who sail on rickety ships and inhabit disordered homes. Moreover, he states that some of them are allegedly remunerated in shady ways, a proportion (it would appear a large one) are derelict in not declaring conflicts of interest when they function in their role, and they do not care about abuses that they well may be committing. Evidently, we all know that a big problem stares us in the face but we studiously avoid dealing with it.

No evidence is marshalled for this rather harsh indictment. On the contrary, the impression gained is of a member of the ethics "industry" (as he himself puts it) who is riding a hobby horse and is disillusioned about what he may have observed in the course of serving as an ethics consultant (he refers to "former" in this regard which suggests that he has withdrawn from such work).

I am always wary of *ad hominem* arguments and therefore searched diligently for what the author might be getting at. I did identify a thread, namely the impermissibility of concealing or disguising a conflict of interest in ethical decision-making. Loss of impartiality invariably follows with the interests of the consumer trumped by those of the provider. One can have no dispute with this contention. A declaration of a conflict of interest is required in many situations linked to the provision of health care although it is true that the degree of pressure on moral agents varies from stringent to *laissez-faire*.

The author then lashes out at one group of moral agents, professional ethicists, who he asserts do not take their job seriously since they have been adversely affected by their biased education, especially if it was obtained in religious institutions. Thus, for example, they may in their commitment to euthanasia fail to disclose their strongly held convictions and impose them on a vulnerable family. As mentioned earlier, no evidence is offered to the reader for these claims. The assumption prevails that anyone trained to hold particular views on euthanasia or any other vital issue in health care is apt to act duplicitly and withhold his personal views from consultees, whether they be family or medical hospital staff.

The emergent suggestion that, in the wake of this messy state of affairs, all ethicists under consideration for appointment to an ethics committee should be instructed to disclose their potential conflicts **before** any appointment is made is nebulous and impractical. How could a proposed appointee determine a continuing range of potential conflict of interests. How could she ever devise such a list without knowing exactly all her inclinations in every sphere of health care? The author attempts to do precisely this at the end of the article by declaring his preference for pragmatism, scepticism for theory and his position concerning five medical interventions. Omitted are dozens of other bioethically complex situations encountered in health care that might well come his way as a consultant ethicist. Surely, to be consistent, he would need to provide an exhaustive list so that potential conflicts of interest are transparent in all these circumstances?

A case could be made for pragmatism, particularly in the form of an agreed upon code of ethics for ethicists. This could contain core principles and associated practically-oriented annotations to guide ethics consultants in their work. Robert Baker<sup>1</sup> has suggested just that in proposing that bioethicists should devise a series of guidelines for their own job of assisting other professions to deal with ethical challenges and quandaries. He has also offered a draft code to his colleagues for their deliberation. His argument revolves around the concept of codes reflecting the "professionalisation" of a group of practitioners who should assert the "integrity and independence" of their enterprise, and offer to themselves and to the public an "... authoritative interpretation of its mission, ideals and practices." Baker's draft code, including its section on conflicts of interests, is reasonably clear and coherent. Thus, ethicists should avoid, and refuse to be involved in, situations that create or appear to create conflicts of interests; they should not serve as consultants where they have "conflicting clinical and/or administrative responsibilities, or intellectual or financial interests."

Although Baker attempts to define the field of bioethics and the corresponding role of the bioethicist, it remains unclear whether his code applies to the clinical sphere only or also encompasses bioethicists who assist in devising policy or consult to corporate bodies.

That the initiative to produce a code for bioethicists may not be all that straightforward is evident in the diverse array of views expressed by 16 prominent experts invited to comment on Baker's draft. The position of one of them, the renowned moral philosopher Tom Beauchamp,<sup>2</sup> is salutary; yes, the idea of codifying an "ethics

for bioethics” is to be applauded but Baker’s draft has conceptual, theoretical and practical limitations, especially in his failure to define and elaborate a range of core concepts. Is the effort therefore a futile exercise? Not at all. As Beauchamp concludes: “No one ever said that codes are easy to write.”

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## **A Commentary in Response to: By What Authority? Conflicts of Interest in Professional Ethics**

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Note: the author of this commentary was blinded to Dr. Charland's identity.

The author of "Conflicts of Interest in Professional Ethics" argues that work by health care ethics professionals is laced with conflicts of interest that ethicists by-and-large fail to "recognize and eradicate". Of particular concern to the author are "undeclared or partisan ethical biases and agendas" in ethics education, clinical ethics consultation, policy ethics consultation and ethics committee work. The author insists that "ethicists must be ethically accountable to those they serve... they must declare any ethical conflicts of interest they may have".

In very general terms, transparency is a good thing and the author's effort to model this by sharing personal information about his/her value commitments is interesting. Arguably, however, this exercise in disclosure doesn't "eradicate" conflicts of interest.

James Orłowski and Leon Wateska helpfully define a conflict of interest as "a discrepancy between the personal interests and the professional responsibilities of a person in a position of trust" (Orłowski and Wateska 1992, 273). And, with more specific reference to medicine, Dennis Thompson defines a conflict of interest as "a set of conditions in which professional judgment concerning a primary interest (such as a patient's welfare or the validity of research) tends to be unduly influenced by a secondary interest (such as financial gain)" (Thompson 1993, 573).

The point I want to insist upon in this brief commentary is that in many instances of conflict of interest, disclosure is an insufficient response and we must guard against any complacency that would have us believe otherwise. To be more precise, there are instances in which persons in positions of trust must show themselves to be trustworthy by removing themselves from actual, apparent, or potential conflicts of interests. That is, there are times when exit, as opposed to disclosure, is required. Carl Elliott makes this sort of point in his discussion of the growing credibility problem for North American bioethicists who accept funding from the pharmaceutical and biotechnology industries and who collaborate with entrepreneurs in publishing scholarly ethics articles. Elliott writes: "The authors of these articles have disclosed their industry ties, but readers are left to wonder: is the industry-funded bioethicist a bioethicist we can trust?" (Elliott 2005, 422) The answer provided to this rhetorical question is "industry funding will surely lead readers to question the impartiality of bioethics as a discipline..."

Disclosure policies raise a red flag and should be retained, but they do nothing to eliminate the real problem of industry funding, which is not secrecy but influence-peddling" (Elliott 2005, 422, 423).

Financial interests of the type alluded to by Elliott are not the only personal (i.e., secondary) interests that may conflict with professional (i.e., primary) interests and responsibilities. Other personal interests include interests in fame and recognition, career advancement and friendship. Indeed, when health care ethics professionals are called upon to provide ethical expertise and advice as members of governing boards, advisory boards, regulatory committees, peer review committees, professional working groups and research ethics committees, it is these sorts of personal interests, more so than financial interests, that may conflict with professional obligations. And when (for legitimate reasons) the ethicist is simultaneously a member of multiple committees with overlapping mandates, the conflicts of interest may be particularly acute (Downie 2006). A personal example will serve to illustrate the point.

In 2001, several senior members of the Canadian bioethics community (myself included) were members of two or more of the following committees: the Canadian Biotechnology Advisory Committee (CBAC), the Board of Directors of Genome Canada, the Science and Industry Advisory Committee (SIAC) of Genome Canada, and the Canadian Institutes of Health Research (CIHR) ad hoc Working Group on Stem Cell Research. At the same time, we were also Principal Investigators with the newly-established Stem Cell Network (SCN), a national multi-disciplinary research team funded under the Networks of Centres of Excellence program.

CBAC's mandate was three-fold: (i) to provide the federal government with policy advice on the ethical, legal, social, regulatory, economic, scientific, environmental and health aspects of biotechnology; (ii) to provide Canadians with accessible information on biotechnology issues; and (iii) to provide Canadians with opportunities to inform the policy advice that CBAC might offer the federal government. The SIAC of Genome Canada was mandated to provide the Board of Directors of Genome Canada with advice on genomics and proteomics research and on ethical, environmental, economic, legal and social issues relating to such research. In turn, the Board was responsible for developing and implementing a national research strategy for genomics and proteomics. The CIHR ad hoc Working Group on Stem Cell Research was established to determine the conditions under which individuals and institutions funded by Tri-Agencies (i.e., the CIHR; the Natural Sciences and Engineering Research Council (NSERC); and the Social Sciences

and Humanities Research Council (SSHRC)) could pursue stem cell research, consistent with the existing ethical framework for research involving humans (i.e., *The Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*). The SCN's mandate was to research the therapeutic potential of stem cells.

From the outset, I was concerned about the overlapping roles of researcher (i.e., Principal Investigator with the SCN) and policy adviser (i.e., member of CIHR ad hoc Working Group) as these roles were in the same area of science, namely stem cell research. For my own part, I sought to manage any potential for perceived or actual conflict of interest, by ensuring that I received no research funds from the SCN while I was a member of the CIHR ad hoc Working Group. In this way I sought to ensure that, at the very least, the roles of researcher and policy adviser were temporally separated.<sup>1</sup>

In sharp contrast, initially I was not concerned about perceived or actual conflicts of interest with the overlapping membership of ethics and law experts on the various national committees. While taken together the committees were collectively responsible for advising the federal government, the Canadian public, the research funders and promoters, as well as the research regulators, there didn't appear to be a conflict of interest as the different committees were providing ethical expertise and advice on different areas of science. Concerns about overlapping committee membership did surface, however, when CBAC decided to add stem cell research to its work agenda, thereby introducing an acute conflict of interest for several of us who would ultimately in a position to: (i) advise Government on national policy regarding stem cell research; (ii) educate the Canadian public about "the promise" of stem cell research; (iii) develop the research guidelines for stem cell research; and eventually (iv) stand in line to receive research funds for work on ethical and legal issues relevant to stem cell research.

I raised the issue of conflict of interest with the Chair of CBAC and with colleagues who were in the same position as me because of overlapping membership on various national committees. In my view, though our membership on the various committees was public information, this sort of 'disclosure' was not an adequate response to the problem of perceived or actual conflict of interest. Several of us were now officially in a position not only to influence research guidelines, but also to influence national policy as well as 'public' opinion, all in a direction that would favour research we were involved with. Disclosure about committee membership would not diminish our influence.

To my surprise, my concerns about conflict of interest were uniformly dismissed. In the end, I saw no way to deal with the risk of partiality or bias, but to tender my resignation from CBAC. In my view, exit was the only ethically defensible option. Interestingly, my decision to resign met with resistance and none followed my lead.

In closing, I commend the author of "Conflicts of Interest in Professional Ethics" for shining a light on an important problem for contemporary bioethics in North America. My contribution to the discussion has been to angle that light toward the remaining penumbra in an effort to show that disclosure is not always a sufficient response to a perceived or actual conflict of interest. Sometimes there is an obligation to eliminate not merely "attenuate" a conflict of interest, in which case there is an obligation to recuse oneself.

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# Perceptions of Psychiatric Advance Directives Among Legal and Mental Health Professionals in Ontario and Quebec

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## ABSTRACT

In an exploratory context, a qualitative approach was used to document perceptions of psychiatric advance directives (PADs) among legal professionals (n=50) and mental health professionals (n=150) in Ontario and Quebec. A Web survey was administered and a qualitative analysis approach was used to explore attitudes towards PADs. It was found that legal and mental health professionals hold different values related to clinical, ethical and legal issues, which may be related to their professional training. Among the advantages associated with PADs include their ability to document a mentally ill individual's clear wishes, respect autonomous choices and foster collaborative treatment. Reported disadvantages of PADs include the possibility of new circumstances arising, mentally ill individuals may not comprehend completing a PAD, and whether a mentally ill individual should be permitted to refuse treatment on ethical grounds.

"PADs always pose difficulties because of competing ethics: autonomy and self determination vs. best interest and paternalism. When a person is unable to exercise their will they are no longer fully autonomous and the need to act in their best interest is the default position unless prior autonomous choice is known."

— Psychiatrist

"I am willing to implement PADS in order that a person's right to dignity, freedom and self-determination is preserved."

— Lawyer

## Introduction

Psychiatric advance directives (PADs) are legal tools allowing mentally ill individuals to document prospective treatment choices in the event of becoming incompetent in the future (Elbogen et al., 2007; Swanson, McCrary, Swartz, Elbogen, & Van Dorn, 2006; Swanson, Swartz et al., 2006; Swartz & Swanson, 2007). PADs offer the potential to empower mentally ill individuals, but also raise ethical questions regarding the right to autonomy, how coercion should be used to leverage choice, and the role of the consumer in making treatment choices (Swanson, McCrary et al., 2006). Understanding mental health professionals' views of PADs (Van Dorn, 2005; Swartz et al., 2005; Von Dorn, 2005), along with those of legal professionals (O'Connell & Stein, 2005), is critical to handling issues of treatment refusal, medication compliance, and empowerment.

PADs question the degree that mentally ill individual's autonomous choices will be genuinely respected (Macklin, 1987; Ritchie, Sklar, & Steiner, 1998; Sass, 2001; van Willigenburg & Delaere, 2005). The ethical theory of principlism holds that, "respect for the autonomous choices of persons runs as deep in common morality as any principle, but little agreement exists about its nature, scope, or strength" (Beauchamp & Childress, 2001). Mental health and legal professionals have ethical obligations to assist mentally ill individuals find ways to regain loss of autonomy, and to that end PADs may increase feelings of self-determination and empowerment (Kim et al., 2007).

Both Ontario and Quebec law permit mentally ill individuals to make advance directives, much in the same way as individuals with physical difficulties are able to do so. Quebec uses 'Mandates in Case of Incapacity' that allow a mandator, while in full possession of his faculties, to appoint another individual, the mandator, to protect or administer property and for the protection of the mandator's person in the event of becoming temporarily or permanently incapable (CCQ, 2130-2137). Ontario uses a proxy directive in the form of a Power of Attorney for Personal Care, a

legal document whereby individuals can name someone to make decisions about their care in the event they become incapable (SDA, 46-53). Personal care includes decisions about health care, medical treatment, nutrition, shelter and hygiene.

Legal and mental health professionals do not always share similar values towards ethical choices made by psychiatric patients. With respect to treatment choices, psychiatrists will not share identical concerns as lawyers, and psychologists do not have a similar outlook as social workers. Although mental health consumers express enthusiasm about completing PADs, clinicians are not always aware of them (Kim et al., 2007). A shared decision-making approach can help resolve some of the ethical strain that arises in the physician-patient relationship (Hamann, Cohen, Leucht, Busch, & Kissling, 2007; Schauer, Everett, del Vecchio, & Anderson, 2007); nevertheless, competing values such as personal and clinical autonomy must weigh in on both sides of the ethical equation (Hundert, 1987; Purtillo, 1980). A values-based framework in mental health ethics offers a novel approach to clinical decision-making by negotiating individual values with the development of best evidence (Petrova, Dale, & Fulford, 2006). Interest is growing in Canada on how implementing PADs would interact with mental health legislation and ethical and legal aspects of the right to refuse treatment (Ambrosini & Crocker, 2007). Thus, the objectives of this qualitative analysis study were to explore competing ethical values among mental health and legal professionals, to assess their views of advantages and disadvantages of PADs, and examine willingness to use them in practice.

## Methods

### *Participants and Recruitment*

The current report is part of a larger study conducted on perceptions of PADs (Ambrosini, Crocker, Israël, & Perreault, submitted). A convenience sample of legal professionals (N=50) and mental health professionals (N=150) in Ontario and Quebec were invited to complete a web survey that measures attitudes towards PADs. To recruit participants, we contacted professional associations, asking them to forward an email to their members as an invitation to participate. The email contained a hyperlink to the web survey allowing participants to provide informed consent and respond accordingly.

Legal professionals included lawyers specializing in health law and administrative tribunal members from Review Boards. Lawyers were recruited through the Ontario division of the Canadian Bar Association's Health Law Section and the Québec division 'Section droit de la santé'. A total of n=30 lawyers responded to the survey with 67% from Ontario, 30% from Québec, and 3% from a mixed jurisdiction (licensed to practice in Québec and Ontario). Administrative tribunal members of Review Boards conduct specialized judicial hearings related to consent and capacity issues for psychiatric treatment, which include lawyers, psychiatrists, psychologists or community members. The Ontario Consent and Capacity Board, Ontario Review Board and *Tribunal Administratif du Québec* agreed to participate. In total, n=29 administrative tribunal members participated.

Mental health professionals included psychiatrists and psychologists. Psychiatrists from Ontario and Quebec were recruited through the Canadian Psychiatric Association and a convenience sample of psychiatrists through the Douglas Mental Health University Institute's network. In total, 98 psychiatrists participated, with 71% from Ontario, 12% from Quebec and 16% from a mixed jurisdiction (both Ontario and Québec). Psychologists from Ontario were recruited through the Ontario Psychological Association and a listserv of Québec psychologists hosted by Laval University in Québec City. Among the 50 psychologists who participated, 59% practiced in Ontario, 31% in Québec and 5% were from a mixed jurisdiction. More information regarding the sample description is described elsewhere (Ambrosini, Crocker, Israël, & Perreault, submitted).

### *Web Survey*

A bilingual, online web-survey was designed (Remark Web Survey 3, 2003). Two open-ended questions assessed: (i) perceptions of advantages and disadvantages of PADs and, (ii) willingness to use PADs. These two open-ended questions were part of larger 39-item web-survey (Ambrosini, Crocker, Israel, & Perreault, submitted). The first question was asked at the beginning of the survey and the second question was asked at the end of the survey. It is possible that responses to the second question at the end of the survey may have been influenced by responses to the first question and the survey items. The survey was pilot-tested and revised before administered to the participants. Among the 200 participants, 97% (n=193) responded to the first question on advantages and disadvantages, and 95% (n=189) responded to the second question related to willingness to begin using PADs.

### *Analytical Procedure*

Each response was read and coded inductively through an emerging categories approach by two individuals and then classified into two major themes: advantages or disadvantages. These responses were then sub-categorized into major themes by frequencies of recurrent unifying concepts using a qualitative software program (QSR N6, 2000). The advantages (Table 1) and disadvantages (Table 2) were classified and coded according to categories that emerged from the analysis. A single response could contain multiple advantages or disadvantages. A participant perspective coding scheme was used to identify if the participant had a positive, negative, or indifferent attitude towards PADs. Responses from the second question were coded further into three sub-categories: (i) willing (a clear statement made in favor of PADs); (ii) unwilling/reluctant (a clear statement not in favor of PADs); or (iii) neutral (no definitive comment or specific neutral statement towards PADs). The goal of these qualitative analyses was to explore and contextualize these open-ended responses.

### *Data Collection*

The data was collected from a securely encrypted website by a senior computer technician at the Douglas Mental Health University Institute, accessible only through a data key with a 128 bit encryption code.

**TABLE 1 ADVANTAGES OF PADs REPORTED BY LEGAL AND MENTAL HEALTH PROFESSIONALS**

Emerging Category	Category Definition	Legal Professionals		Mental Health Professionals	
		n	%	n	%
Predictability	PADs provide a predictable and consistent approach to honoring wishes	16	4	23	2
Dignity	PADs respect an individual's dignity	1	-	26	3
Autonomous choice	PADs foster independence, autonomy, self-determination, and treatment choices which allow the individual to control decision-making	78	19	196	23
Clear wishes	PADs help identify, respect, and uphold an individual's earlier stipulated clear wishes when made in a competent frame of mind	141	35	161	19
Collaborative treatment	PADs foster collaboration between psychiatrists and/or treatment teams	89	22	101	12
Legal concerns	Any positive legal reference to PADs upholding prior competent wish	7	2	34	4
Family/ SDM	PADs have positive effects on families and/or substitute decision-makers	38	9	76	9
Empowerment	PADs protect the mentally ill from coercion or paternalism	4	1	15	2
Medical benefits	PADS have positive medical or psycho-medical treatment benefits	12	3	112	13
Protection	PADs protect the mentally ill from coercion or paternalism	6	1	41	5
Liberty rights	PADs foster libertarian rights of the mentally ill	9	2	24	3
Systemic policy change	PADs encourage positive government or hospital policy changes	0	-	32	4
<b>Total Responses</b>		<b>401</b>	<b>32</b>	<b>841</b>	<b>68</b>

### **Ethics Approval**

This study was submitted and received expedited approval by the McGill University Health Center Research Ethics Board and the Douglas Mental Health University Institute's Research Ethics Board.

### **Results**

Among the 193 participants who responded, it was found that the highest proportion of reported advantages of PADs is their ability to document clear wishes, honour autonomous choices, encourage collaborative treatment, provide medical benefits, include family and substitute decision-makers, protect individuals from coercion, uphold prior competent wishes through the law, offer predictability in decision-making, respect liberty rights, encourage systemic policy changes, respect dignity and empower the mentally ill.

The most frequently reported advantage of PADs was that they

encourage others to respect any clearly documented wishes made by an individual while competent:

"The advantage is the same as for other advance directives: to make clear at the time of decision-making what the patient's wishes were at the time of making the directive. One might believe that this would lead to less confrontation and confusion at the time a decision has to be made."

— Lawyer

"Advantages are the same for all advance directives - they allow a person to have a say in their treatment at a future time when they have become incapable of making a decision about treatment."

— Psychiatrist

"A valid capable wish should be followed by the substitute decision-maker and the treatment team... There must also be a system to review and interpret PADs to determine whether wishes are valid or what the individual actually meant."

— Rights Adviser

**TABLE 2 DISADVANTAGES OF PADs REPORTED BY LEGAL AND MENTAL HEALTH PROFESSIONALS**

Emerging Category	Category Definition	Legal Professionals		Mental Health Professionals	
		n	%	n	%
Non-comprehensive	PADs are not comprehensive enough to deal with all possible contingencies that may arise	15	3	55	5
Lack awareness	Skepticism of PADs as not being completed while fully aware, capable, or competent with all mental faculties for truly informed consent	65	16	185	15
Self-bound	PADs bind prior competent wishes in the form of a self-binding contract which cannot later be revoked	22	5	174	6
Better treatment	PADS do not account for better medical treatment made available in the future, which binds the individual to outdated treatment	46	10	109	9
Treatment refusal	PADs should not allow mentally ill to refuse medical treatment	60	13	133	11
Professional non-compliance	PADs discourage collaboration and compliance between mental health professionals and mentally ill individuals	30	7	87	7
Overbroad	PADs are overbroad in what they allow to be included in the documents	15	3	15	1
Perpetuates illness	PADs will translate into mental illness being perpetuated	7	2	98	8
Economics	PADS have a negative cost or economic effect	11	2	24	2
Restricts liberty	PADs actually restrict the rights and liberties of mentally ill individuals	9	2	10	1
New/changed circumstances	New or changed circumstances may arise so that prior wishes should be revised	72	16	38	3
Legal concerns	Any reference to PADs as having a negative legal consequence	29	7	115	10
Validity	PADs are not or should not be considered valid documents	12	3	12	1
Family/SDM	PADs discourage family and/or substitute decision-makers collaboration	16	4	116	10
Hospital detention	PADs keep mentally ill individuals detained in hospital indefinitely	20	4	66	5
Bureaucratic challenges	PADs are seen as bureaucratic	12	3	21	2
Danger/safety concerns	Leaving mentally ill individuals untreated increases dangerousness, threat, and safety concerns to the public	0	-	28	2
More research needed	More research required regarding PADs before willing to make a definitive comment	5	1	17	1
<b>Total responses</b>		<b>446</b>	<b>27</b>	<b>1203</b>	<b>73</b>

Another reported advantage of PADs was their ability to foster self-determination and honor the autonomous choices of mentally ill individuals:

“One advantage is that by completing the PAD the individual feels that he/she has some control over her/his life, and has input into the course of treatment, thus does not feel helpless, or at the mercy of others who may be perceived as having power over him/ her.”  
— Administrative tribunal member

“Favorable prejudice based on my knowledge of wills at the end of life and the right to self-determination.”  
— Lawyer [translated]

Mental health and legal professionals value the importance of collaborative treatment in contemplating to document a PAD:

“The advantage is that the individual is actively involved in his future treatment. The disadvantage is that...at the moment of a crisis that they know better than when the individual was competent. It is essentially an argument between professionalism and individual rights to self determine their future.”  
— Psychiatrist

“Integrates patient and his family in making decisions, fosters better collaboration between health care professionals and treated patient.”— Psychiatrist [translated]

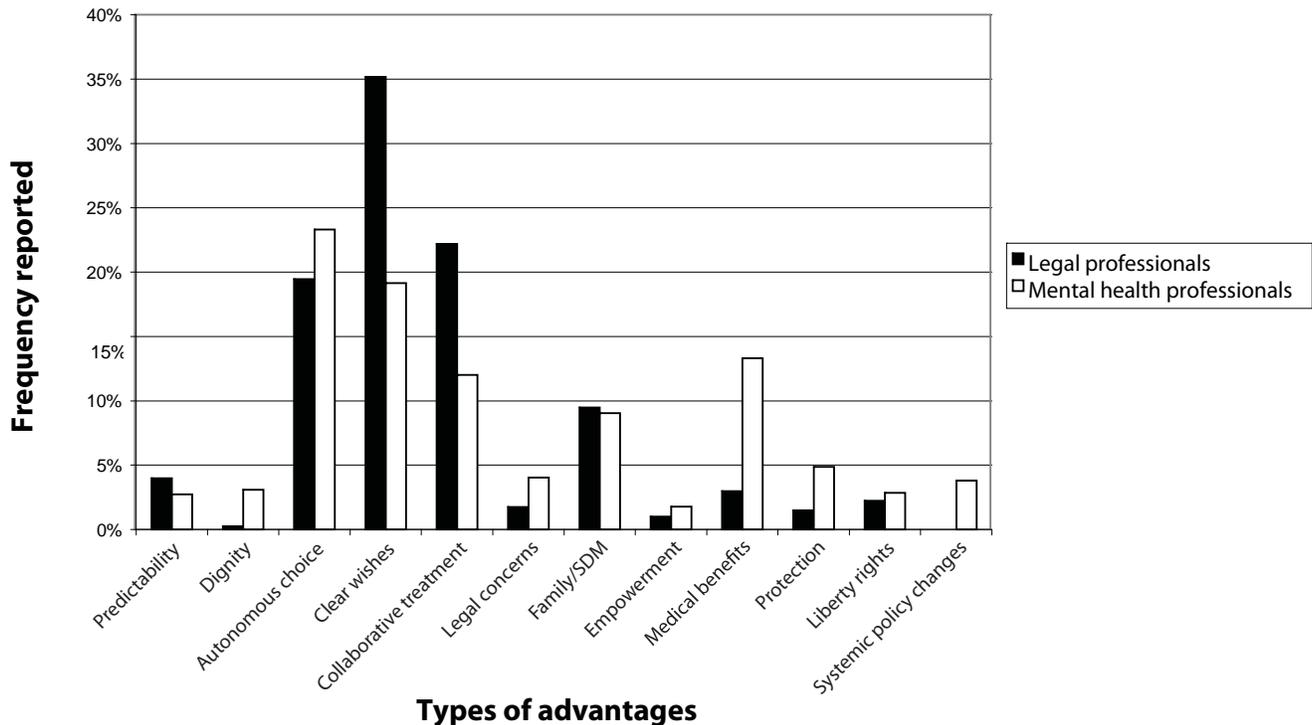
The top three advantages of PADs cited by legal professionals are that they are useful to document clear wishes, foster collaborative

treatment and respect autonomous choice. Mental health professionals focused on PADs ability to respect autonomous choices, document clear wishes, offer medical benefits and encourage collaborative treatment (see Graph 1). For example, only 3% of legal professionals associated PADs with medical benefits, compared to 13% of mental health professionals.

Furthermore, we found that psychiatrists, psychologists, lawyers and community members hold different perceptions of advantages associated with PADs (see Graph 2). Psychiatrists associated PADs with possible medical benefits more frequently than lawyers. Lawyers, on the other hand, reported that PADs can be used to document clear wishes and offer predictability in decision-making more than community members, psychiatrists, and psychologists. Community members highlighted PADs’ potential to promote collaborative treatment as an advantage.

We also found that advantages of PADs may be related to the jurisdiction a professional practices in, whether Ontario or Quebec. Quebec professionals reported more frequently than Ontario professionals that PADs offer the advantage of documenting clear wishes and providing legal protection. Quebec professionals saw PADs as offering greater legal advantages than Ontario professionals. Conversely, Ontario professionals reported that PADs have greater advantages in medical benefits compared to Quebec professionals. The results of the quantitative part of this study suggest that Quebec professionals are less familiar with PADs, but more willing to start using them in their professional practice (Ambrosini, Crocker, Israël, & Perreault, submitted). More re-

**Graph 1. Advantages of PADs by profession**



search in a larger sample would be required to determine whether the differences between provinces are meaningful. However, it is possible that differences in familiarity may be partly related to the terminology in provincial legislation, where Quebec refers to Mandates in Case of Incapacity and Ontario uses the expression advance care planning.

**Disadvantages of PADs**

We found that the disadvantages associated with PADs could be categorized into 18 themes (see Table 2). Among the most frequently reported disadvantage of PADs was that mentally ill individuals may lack awareness to fully understand the document they are completing:

“The main disadvantage would be to accurately judge the capacity at the time of the implementation of the PAD.”  
— Psychiatrist

“People filling these documents do not necessarily have the capacity to make an informed decision, even when not in crisis; the refusal of treatment is problematic because it can lead to dangerous situations for ourselves and for others thereafter (e.g. paranoid individuals).”  
— Psychologist (translated from French)

“Disadvantages are that it is often difficult to completely ascertain that an individual is capable of making these decisions as it is difficult to assess the effect of their illness on capacity.”  
— Psychiatrist

The second most frequently reported disadvantage of PADs is that mentally ill individuals may not fully understand the treatment choices they are making:

“It’s great to allow people to plan, but do they truly recognize the situation that they will find themselves in and the problems that PADs may cause for their treatment. The Starson case is a prime example, where the patient ended up in a secure locked ward for a long period of time because no treatment was undertaken.” — Lawyer

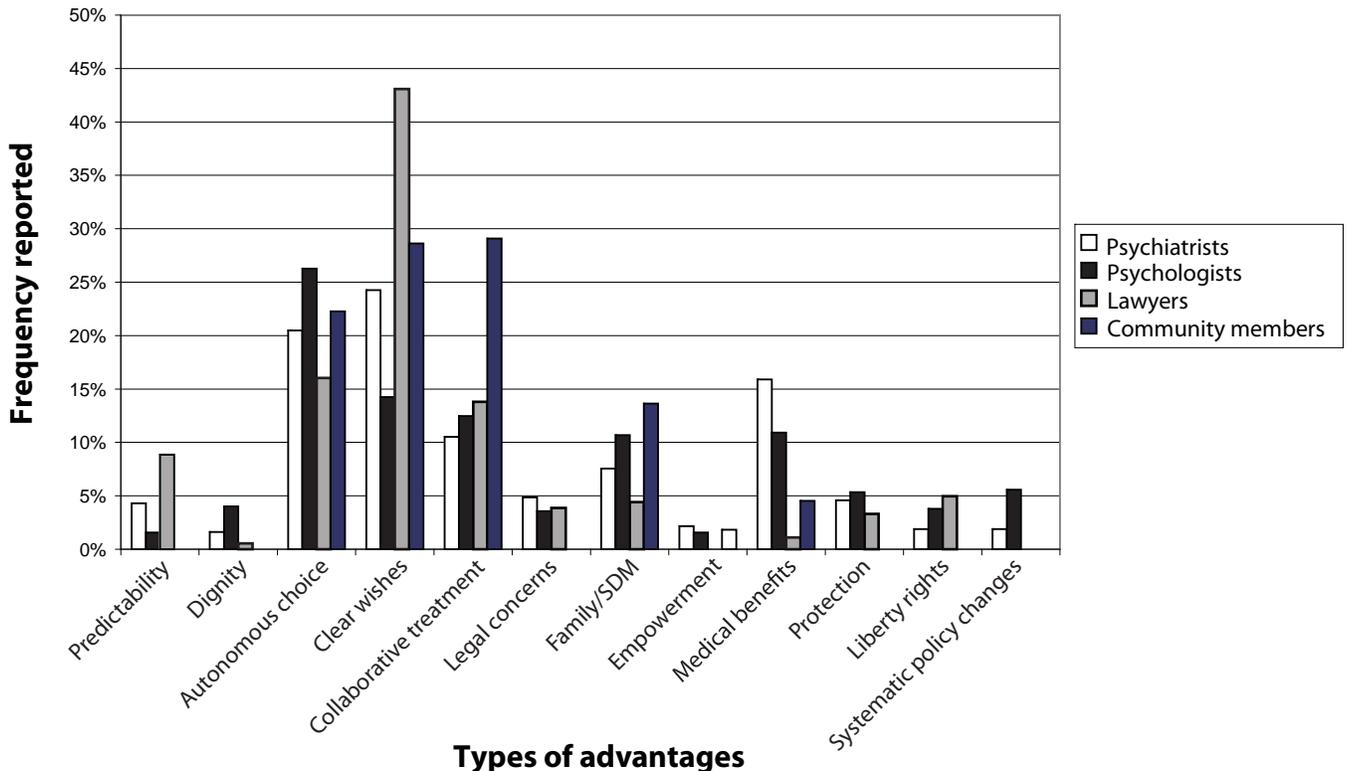
“I have seen the damage to patients and their families from refusal to obtain proper psychiatric treatment.”  
— Psychiatrist

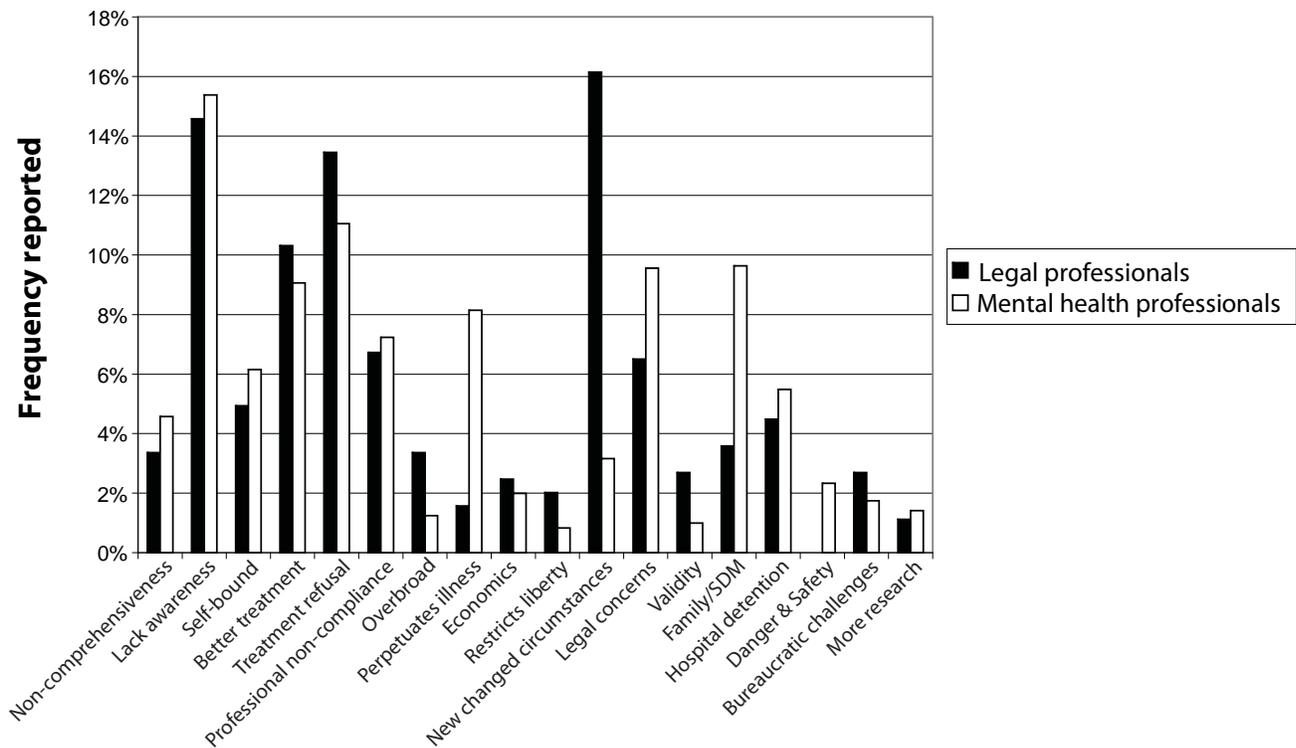
“I am reluctant to be in the moral/ethical situation when I have someone coming to me acutely ill, in danger of dying, suffering, and having my hands tied by a PAD such that I am unable to treat their illness when it would otherwise be treatable. It contravenes my oath to do no harm to my patient because I feel my not treating would be causing harm to my patient. I worry that bringing PADs without educating the public about mental illness and its treatment is dangerous.”  
— Psychiatrist

Others were concerned that better treatment may become available and incompetent individual may not fully understand its potential benefit:

“The disadvantage is that it may not cover every circumstance that may arise, and therefore be unclear in some

**Graph 2. Advantages of PADs by profession**



**Graph 3. Disadvantages of PADs by profession**

### Types of disadvantages

situations. I do not believe that mental health professionals should be permitted to disregard instructions in a PAD if evidence reveals better treatment exists.”

— Rights advisor

“They may interfere with required or unforeseen treatment.”

— Psychologist

“...Inability to foresee new treatment (medications), not yet developed, which might arise in the future and for which consent has not been obtained.”

— Consent and Capacity Board member

Another reported disadvantage of PADs as a Ulysses contract, an advance directive allowing an individual to authorize prior requests regarding treatment, is that its self-binding nature freezes earlier wishes:

“Persons who have an ongoing medical problem can, while well, direct that they not receive any medication when they are ill and that can have significant lasting effects. To the contrary, they could implement a Ulysses clause, while they are well, which would preclude them from taking any action to prevent a doctor from treating them while ill.”

— Lawyer

“...The disadvantage is that an opinion of the subject could have changed but remains ‘frozen in time’ as it were which could have its own detriment to the subject’s well being or wishes.”

— Psychiatrist

“...Disadvantage is the potential for locking in a no-treatment directive when circumstances and treatment have evolved.”—Psychiatrist

Professionals saw PADs as possibly creating legal issues, but some believed that current mental health legislation is adequate to deal with such issues:

“Existing legislation seems adequate enough. Keep it simple.”— Psychiatrist and Consent and Capacity Board Member

“...prior capable wishes already are a part of the legislative framework guiding the decisions of substitute decision makers. PADs are in my opinion more likely to do harm than good and are largely unnecessary.”— Psychiatrist

“I want to know more about them and see what the legal ramifications are before I commit.”— Psychiatrist

“...Wary due to concerns of legal liability from not treating.”— Psychiatrist

“PADs is to lawyers as hay is to farm animals.”— Psychiatrist

The top five disadvantages of PADs, as reported by legal professionals, were new/changed circumstances, lack of awareness, treatment refusal, better treatment, legal concerns, and professional non-compliance (see Graph 3). Mental health professionals reported the top five disadvantages as lack of awareness, treatment

refusal, legal concerns, family/substitute decision-maker and better treatment.

Among disadvantages of PADs, psychiatrists saw lack of awareness, ability to refuse treatment, and the possibility for better treatment as barriers as most significant (see Graph 4). Psychologists, on the other hand, reported that treatment refusal, lack of awareness, and legal concerns were primary disadvantages. Lawyers believed that PADs may create concerns regarding new and changed circumstances, potential for better treatment, and the lack of awareness. Community members saw treatment refusal, new and changed circumstances, and lack of awareness as primary disadvantages.

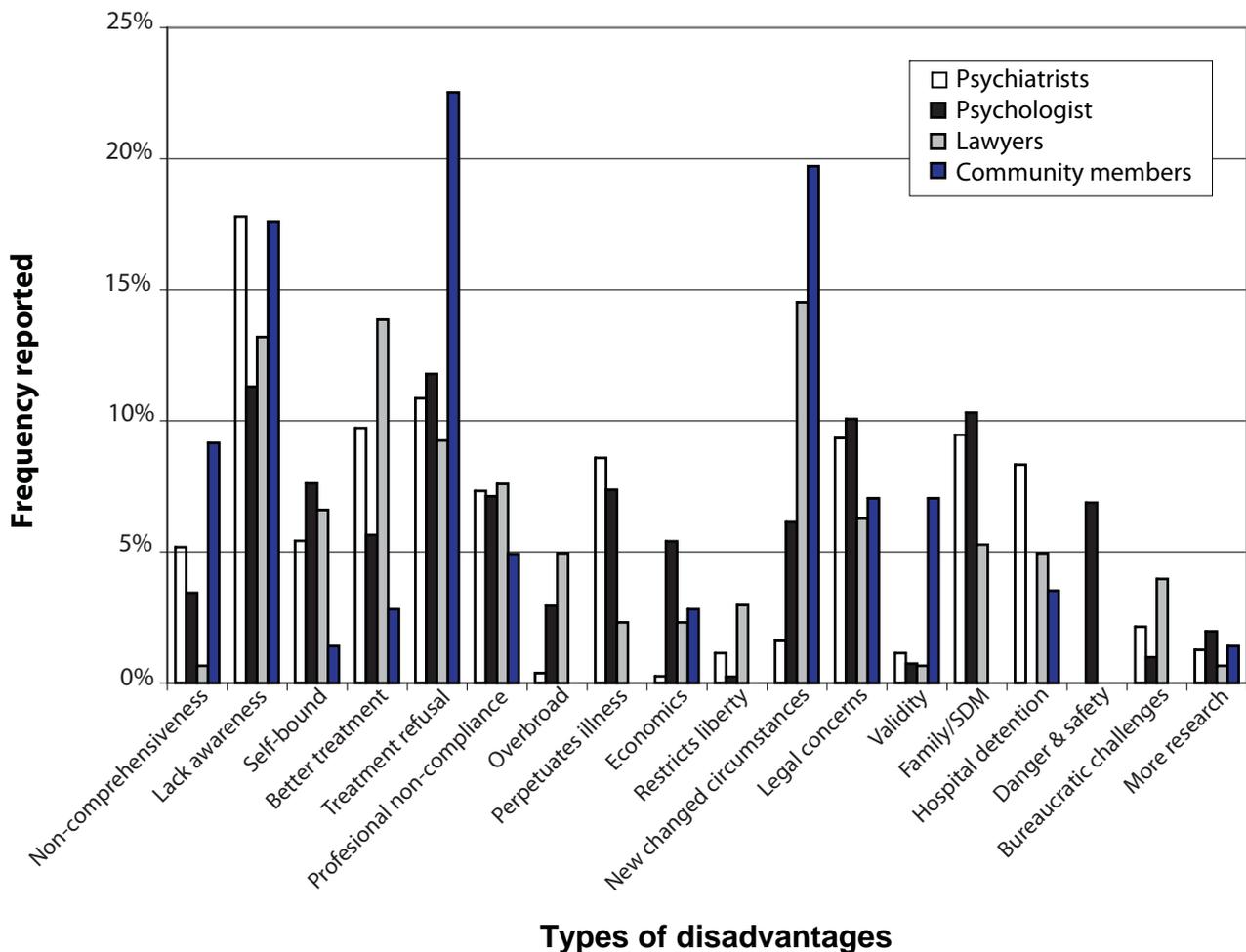
When asked about willingness to begin using PADs within professional practice, it was found that approximately 40% of legal professionals leaned toward their application, 32% did not, and 29% were neutral. Mental health professionals were slightly more favorable to implementing PADs than legal professionals, with 47% towards yes, 25% towards no, and 28% were neutral. Approximately 50% of psychiatrists indicated their willingness to using PADs compared to 40% of psychologists, 40% of lawyers, and 39% of community members. At the same time, 39% of lawyers and 36% of psychiatrists were definitive in their views not to implement

PADs, compared to 10% of psychologists and 14% of community members. Psychologists and community members were more likely to be neutral with respect to implementing PADs compared to psychiatrists and lawyers. Whether comparing professionals (legal or mental health) or jurisdiction (Ontario and Québec), willingness to implement PADs was around 44-45%.

### Discussion

Results based on the responses of 193 participants from Quebec and Ontario suggest that less than half of legal and mental health professionals are willing to start using PADs. When asked about their willingness to use PADs, the intention was to determine whether professionals would promote the documents. As a matter of mandatory compliance with law mental health professionals may be bound to honor them. The issue of whether they can be overridden would need to be decided by a Canadian court of law. However, the fact that 50% of professionals are not yet willing to use them indicates some reservations about promoting them; it does not tell us whether they would override them.

**Graph 4. Disadvantages of PADs by profession**



Understanding legal and mental health professionals' values towards issues such as treatment refusal and ethical choices is an important preliminary step in better understanding whether PADs may be accepted. Professionals from different perceptions hold different values with respect to using PADs, as evidenced by psychiatrists and lawyers more definitive responses in their willingness to use PADs than psychologists and community members.

Legal professionals see PADs' ability to capture an individual's clear wishes and offer a potentially valuable collaborative relationship between patient and physician than do mental health professionals. Mental health professionals may not have sufficient knowledge about how PADs can operate to foster a collaborative treatment alliance; whereas legal professionals see the patient-physician relationship more from a litigiousness outlook.

Mental health professionals were more perceptive to how PADs may offer potential medical benefits to patients than legal professionals. It is not surprising that mental health professionals were concerned primarily with how PADs may perpetuate illness, whereas legal professionals focused on the possibility of changing circumstances. These different values suggest legal and mental health professionals prioritize advantages and disadvantages of PADs along legal or clinical lines. This provides some support for the finding that the ethics of law emphasizes different values such as autonomy and liberty, while medical ethics focuses on good medical outcomes (Sarkar, 2005). Support for this view is found in lawyers' focus on PADs as a tool to increase predictability in future decision-making, an expected finding given lawyers' tendency to associate certainty and predictability with contract formation. In one sense, PADs are analogous to a contract relationship. Mental health professionals appear to seek greater flexibility and medical discretion to justify overriding a PAD. In order for PADs to be realized it is important they not become overly legalistic. At the same time legal issues cannot be ignored.

This study has significance for policy-makers who draft mental health legislation. PADs may eventually be shown to increase individual's autonomy and improve the physician-patient treatment relationship. Although there is some reluctance to implement PADs while in its early phases, with greater education these perceived disadvantages are not insurmountable. These findings offer an ethical perspective that focuses on understanding professional values.

The Kirby Report, *Out of the Shadows at Last* (2004), recommended making forms and information kits available to mental health patients explaining how to complete advance directives, while at the same time making community-based legal services available to assist in the documentation process. In Canada, where provinces have disparate mental health legislation, it is important to ensure that research findings of what being 'clinically capable' and 'legally competent' to make a prior competent wish signifies are uniformly conveyed in legislation. Respect for patients' prior competent wishes and autonomous choices will depend on understanding the viewpoints of different stakeholders. It is recommended that public education campaigns educating and empowering mentally ill individuals and their families about the importance of collaboration with mental health professionals be emphasized. Using a values history to complete PADs can be done by learning about the patients' views towards personal relationships,

independence, religious beliefs, and mental illness (Peters & Chiverton, 2003). Operational definitions of values, among others, include determining what is important in life to someone, ranking and prioritizing goals and benefits, and ensuring that processes of assigning values is equitable (Petrova et al., 2006). A values-based approach to implementing PADs, in the face of conflicting ethical views, may offer the most sensitive means of showing mutual respect for different professionals' involvement while assisting mentally ill individuals to regain autonomy.

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## PSYCHIATRIC ADVANCE DIRECTIVE SURVEY

**INSTRUCTIONS:** Questions are divided into five page frames dealing with clinical, ethical, legal, implementation and demographic factors. This survey can be completed in 10-15 minutes. There is also an opportunity for you to provide comments. At the end of each page frame click NEXT PAGE to reach the following page and SUBMIT when the survey is complete. You must answer each question to reach the next page frame.

**DEFINITION:** Psychiatric advance directives (PADs) are legal documents allowing competent individuals to declare their treatment preferences in advance of a mental health crisis, in the event they lose mental capacity to make reliable health care decisions. They are self-binding legal documents allowing patients to be actively involved in their treatment, but at the same time may present ethical problems such as the right to refuse medical treatment and the extent to which prior competent wishes are respected. A PAD is most often used when the person who created the document experiences acute episodes of psychiatric illness and becomes unable to make or communicate decisions about treatment.

1. In your view, what are the advantages and/or disadvantages of implementing PADs?

### I. Clinical Factors

Please respond to the following questions:

1= not at all, 4= extremely

2. Are you familiar with PADs? 1----2----3----4
3. Should individuals with severe mental illness be permitted the right to refuse medical treatment? 1----2----3----4
4. Are you concerned with the effects of leaving someone with mental illness untreated? 1----2----3----4
5. How important is it to have a mental health professional present when a PAD is documented? 1----2----3----4
6. Can PADs have a therapeutic value for individuals with serious mental illness? 1----2----3----4
7. How much do PADs undermine the clinical judgment of mental health professionals? 1----2----3----4
8. How much should mental health professionals be permitted to disregard instructions in PADs if evidence reveals better treatment exists? 1----2----3----4
9. In your opinion, how much do legislative policies affect clinical outcomes of individuals with serious mental illness? 1----2----3----4
10. How important are the following criteria to mental health professionals in assessing the clinical capacity of someone with severe mental illness?
  - Understanding ability 1----2----3----4
  - Appreciating ability 1----2----3----4
  - Reasoning ability 1----2----3----4
  - Evidencing a choice 1----2----3----4

### II. Ethical Factors

11. How important are the following ethical values representing an individual's right to refuse treatment?
  - Increasing autonomy 1----2----3----4
  - Decreasing coercion 1----2----3----4
  - Increasing self-determination 1----2----3----4
  - Decreasing stigmatization 1----2----3----4
12. How knowledgeable are you of ethical issues surrounding PADs for the mentally ill? 1----2----3----4
13. How absolute should a patient's right be to decline medical treatment even if the decision is not in the patient's best interests? 1----2----3----4

14. Do you think PADs can reduce stigmatization of mental illness? 1----2----3----4
15. In your opinion, how important is it to consider someone's prior competent wishes before deciding their best interests? 1----2----3----4
16. How concerned are you that if patients refuse to follow medical advice they may be left untreated for lengthy periods of time? 1----2----3----4
17. Are you aware of past abuses against the mentally ill in your province? 1----2----3----4

**III. LEGAL FACTORS**

18. Compared to mental health professionals how knowledgeable are you with the law related to advance directives for incompetent persons? 1----2----3----4
19. Compared to legal professionals how knowledgeable are you with the law related to advance directives for the mentally ill? 1----2----3----4
20. How much legal weight should PADs have as enforceable documents in court? 1----2----3----4
21. Should a judge have the discretion to override a competent person's wish to refuse medical treatment? 1----2----3----4
22. Would PADs assist judges in making accurate decisions about involuntary civil commitment? 1----2----3----4
23. How much should the following individuals be the authoritative decision-maker in determining when a competent wish is valid?
- Psychiatrist 1----2----3----4
  - Judge 1----2----3----4
  - Psychiatric nurse 1----2----3----4
  - Social Worker 1----2----3----4
  - Review Board 1----2----3----4
  - Family members 1----2----3----4
24. How concerned are you that if medical professionals override prior competent wishes in a patient's PAD it may lead to medical malpractice lawsuits? 1----2----3----4
25. To what degree should courts protect prior competent wishes expressed in PADs over clinical decisions made by mental health professionals? 1----2----3----4
26. In your opinion, how familiar are you with mental health legislation and the legal standard of competency in your province? 1----2----3----4

27. How important are the following criteria to legal professionals in assessing legal competence of someone with severe mental illness?
- Understanding ability 1----2----3----4
  - Appreciating ability 1----2----3----4
  - Reasoning ability 1----2----3----4
  - Evidencing a choice 1----2----3----4

**IV Implementation Factors**

28. How knowledgeable are you with the process of documenting advance directives generally? 1----2----3----4
29. Should family members be involved in assisting competent individuals who may develop a mental illness in completing PADs? 1----2----3----4
30. Do PADs merit further research? 1----2----3----4
31. How willing are you to start using PADs in your practice? 1----2----3----4

**V. Demographics & Professional Experience**

Please complete the following information pertaining to your profession:

32. Age  20-30  31-40  
 41-50  51-60  
 61-70  > 71
33. Gender:  Male  Female
34. Ethnic background  
 Caucasian  European  
 African-American  Asian  
 American Indian  South American  
 Other
35. Which professional body do you belong to?  
 Judge- Superior Court  
 Judge- Other  
 Lawyer/Attorney- Medical/health care law  
 Lawyer/ Attorney- Other  
 Psychiatrist- Hospital  
 Psychiatrist- Private practice  
 Psychiatric nurse- Hospital  
 Psychiatric nurse- Private practice  
 Psychologist- Hospital  
 Psychologist- Private practice  
 Social worker- Hospital  
 Social worker- Private practice  
 Other  
 If other (please specify): \_\_\_\_\_

36. Are you an administrative tribunal judge? (i.e. TAQ, Consent & Capacity)
- Yes- Le Tribunal Administratif du Québec
- Yes- Consent & Capacity Board (Ontario)
- Other
- No
37. Where are you licensed to practice your profession? You may check more than one.
- Ontario
- Quebec
- Another Canadian province
- United States
- Europe
- Other
38. How long have you been a practicing member of your professional group?
- < 1 year
- 2-5 years
- 6-10 years
- 11-30 years
- > 31 years

## VI. Contact with Mentally Ill

39. How often do you work with individuals with severe mental illness who are not immediate family members?
- Every day
- Once or twice a week
- Once a month
- Every few months
- Almost never
40. Have you or someone in your immediate family ever been hospitalized for symptoms of severe mental illness?
- Yes  No

## VII. Comments and Suggestions

41. Why are you willing or reluctant to implement PADs?

**Competing Interests:** None.

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## The Blessing and Burden of Biological Psychiatry

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### ABSTRACT

All psychiatric disorders have a neurobiological basis. This has led to a better understanding of these disorders and a reduction in the social stigma associated with them. But the claim that mental states can be explained entirely in neurobiological terms may give us de-stigmatization at the cost of de-personalization. A holistic view of the mind as distributed among the brain, body and environment provides the best model to guide interventions that will have the most salutary effects on the brain and the mind.

*Key Words: anxiety, cognitive-behavioural therapy, depression, environment, neurobiology, obsessive-compulsive disorder, stigma*

Depression, anxiety and other disorders of the brain and mind have never been treated on a par with bodily diseases such as heart disease and cancer. This inequality has persisted despite the fact that psychiatric disorders affect millions of people globally and often involve severe mental and physical disability, lost productivity and impaired quality over much of their lives (World Health Organization, 2004). One recent report estimated that severe mental illness is associated with an annual loss of earnings totaling \$193.2 billion in the United States alone (Kessler et al., 2008). Depression is projected to be the leading cause of burden of disease in developed countries by the year 2030 (Mathers and Loncar, 2006). For years, many claimed that psychiatric conditions did not warrant being classified as illnesses. Diseases of the body were taken seriously. Disorders of the mind were often dismissed as imagined or feigned, presumably because there was no biological basis of their etiology and symptomatology. According to a national survey commissioned by the Canadian Medical Association and released in August 2008, a significant number of people still hold this view. Nearly half of one thousand Canadians surveyed said that mental illness is not always real but an excuse for bad behavior and personal weakness (Canadian Medical Association, 2008).

People with these conditions suffered from a double curse. There were few effective treatments to control or alleviate their psychological and physiological symptoms. And rather than elicit sympathy, they became objects of discrimination and had to endure the social stigma attached to deeply misunderstood conditions. People with neurological disorders such as epilepsy have also suf-

fered from a similar misunderstanding, though not to the same degree as those with psychiatric disorders. This may be due to the fact that for many years electroencephalography (EEG) has been able to detect seizures, and some neurosurgeons have been able to initiate seizures in the temporal lobes of some of their patients. Misunderstanding of mental disorders is partly responsible for the inadequate funding of treatments for these disorders by health care systems in many countries. As a result, millions of people have continued to suffer from untreated or undertreated psychiatric conditions. This has been the most unfortunate legacy of mind-body dualism in medicine.

In an influential paper published in 1998, Eric Kandel outlined the beginning of a new intellectual framework for psychiatry that emphasized the neurobiological basis of the brain-mind relation (Kandel, 1998). Together with advances in genetics, this helped to establish biological psychiatry as the model for diagnosing and treating disorders of the brain and mind. The widespread acceptance of this model is reflected in part by the prominence of *Biological Psychiatry* and similar journals reporting on research and treatment outcomes in clinical psychiatry. It is also partly responsible for the inclusion of more conditions in the *Diagnostic and Statistical Manual of Mental Disorders*. Thanks largely to structural and functional brain imaging, the neurobiological model of the brain-mind relation has done much to discredit mind-body dualism and reduce the harmful effects it has had on people with mental disorders. Neuroimaging can show correlations between structural and functional brain abnormalities and symptoms of these disorders. Imaging can also display and monitor the effects of psychotropic drugs prescribed for these conditions on the brain. This has led to the development of more effective drug therapy. In addition, epidemiological studies of obsessive-compulsive disorder and other psychiatric conditions indicate that their symptoms are strikingly similar across cultures (Matsunaga et al., 2008; Pallanti, 2008; Canino and Alegria, 2008). They are more deeply embedded in common neurobiology than in cultural differences.

These empirical findings confirm that psychiatric disorders do indeed have a neurobiological basis. Biological psychiatry has done much to dispel the view that these conditions are "all in the mind" and as such not illnesses at all. Once it became clear that the brain was the organ that generates and sustains our mental states, and that brain dysfunction could result in mental dysfunction, it also became clear that what occurred inside the head played an important role in shaping the mind. This shift in thinking has helped to attenuate some of the stigma and discrimination experienced by

people with mental illness. It should lead to more public funding of mental health programs so that people suffering from these conditions will receive the treatment to which they are entitled.

The diagnosis and treatment of mental disorders should not be based entirely on neurobiology, however. Physiological and psychological symptoms of many if not most psychiatric disorders are a function not only of the brain but of interaction among the brain, body, and environment. The hypothesis that a maladaptive response to external stimuli plays a key role in the etiology and pathophysiology of major depressive disorder, generalized anxiety disorder, and obsessive-compulsive disorder motivates therapies that aim to alter the individual's relation to the environment. This may be achieved by removing or altering the stimuli causing or exacerbating the brain dysregulation underlying these disorders. Therapies may also consist in helping the individual to reframe his or her beliefs so that the contents of these beliefs align with the actual nature of events to which they are directed. This can alter one's misperception of external events so that one perceives them as opportunities to navigate or engage with rather than as threats to avoid.

Studies of adults and adolescents with moderate to severe depression have convincingly shown that combined pharmacotherapy and psychotherapy, particularly cognitive-behavioral therapy (CBT), is generally more effective than drug treatment alone (Keller et al., 2000; American Psychiatric Association, 2000; Pampallona et al., 2004; March et al., 2007). This combination can help to prevent relapse and make drug treatment safer by reducing the risk of suicidal ideation. A recent study showed that combined antidepressant (SSRI) therapy and CBT resulted in a highly positive response rate in children with anxiety (Walkup et al., 2008). The effectiveness of psychotherapy for depression and anxiety shows the significance of one's mental states and the environment in both the development and treatment of this disorder. The content and qualitative aspects of our beliefs and emotions cannot be separated from the social and natural context in which we have them. Repeated exposure to a fearful situation in a controlled setting may also enable one to reframe one's beliefs so that they align with the actual nature of external events and thereby attenuate anxiety or phobia. This may involve being placed in a particular social or physical setting or in a virtual reality program that mimics these settings.

Addiction is another psychiatric disorder where environmental intervention can be effective in controlling craving and related symptoms. Dopamine antagonists have shown promise for controlling some addictions by modulating a dysregulated mesolimbic dopamine system in the brain (Franken, Booij and van den Brink, 2005). The anticonvulsant drug topiramate has also shown promise for treating cocaine and alcohol dependence (Kampman et al., 2004; Johnson et al., 2007). Research has yielded a better understanding of the underlying neurobiology of addiction (Kalivas and Volkow, 2005). Yet craving a substance can be influenced by social or physical cues reminding the individual of the substance to which he or she is addicted (Elster, 1999; Ainslie, 2000, 2001). Eliminating these cues by altering the social and physical setting or by removing the individual from it is one way of treating the addiction. Depending on availability and access, heroin addicts may go to methadone clinics to control their addictions. All of these measures could be combined with CBT offering the addict incentives to moderate his or her steep discounting of the future

consequences of giving in to the desire for immediate gratification. Brain-environment interactions are critical to the development and treatment of this and other psychiatric disorders.

Imaging studies suggest that psychotherapy can change structures and functions of the brain and thus "re-wire" it in a manner different from the effects of pharmacotherapy (Baxter, 1992; Martin et al., 2001; Paquette et al., 2003; Mayberg et al., 2004). It can have a positive "top-down" effect on prefrontal cortical areas associated with some symptoms of mental disorders, complementing positive "bottom-up" effects of drugs in limbic and subcortical areas associated with other symptoms of these same disorders. Imaging can display the modulating effects of CBT on an overactive anterior cingulate cortex and rostral caudate nucleus responsible for the heightened "worry" circuit implicated in obsessive-compulsive disorder. This is in addition to the ability of imaging to display positive effects of CBT and other forms of psychotherapy on cortical function in patients with depression and anxiety.

Although these results are preliminary and will have to be replicated, they suggest that our mental states are not simply a product of linear causation ("bottom-up") from the brain. The brain is not the sole cause of or influence on the mind but is a relational organ that shapes the mind by mediating interaction between the organism and the external world. (Fuchs, 2008) The mind is not located in the brain but is distributed among the brain, body, and the environment in which the organism, or subject, is situated. (Fuchs, 2008; Clark and Chalmers 1998) Our mental states are the emergent products of circular causation consisting of neurophysiological, environmental, and social influences continuously interacting with each other in a series of positive feed-forward and negative feedback loops (Fuchs, 2004; Fuchs 2005; Kendler 2005). Disordered states of mind result when something goes awry in this process. A chronic negative perception of stimuli from the environment, or a prolonged stress response to these stimuli, can trigger a cascade of pathological events in the hypothalamic-adrenal-pituitary axis and result in the symptoms of depression or anxiety. The causal pathway goes from the mind, or the subjective experience of the situation, to the brain and body, and then back to the mind. Yet dysregulation of the brain and mind can be ameliorated or corrected by intervening in a critical part of this pathway and altering the subject's beliefs about the environment. This suggests that mental states are not epiphenomenal to brain states but can have a causal influence on them.

The effectiveness of psychotherapies that utilize environmental influences on the brain and mind supports the circular causation model for understanding and treating at least some mental disorders. Therapies that enable one to reframe beliefs do not just have positive effects on cognition or mood. More importantly, these effects can change the subject's behavior so that he or she can once again engage in interpersonal interaction and experience positive relations with others in the world. Drug therapy targeting the relevant neuronal pathways and neurotransmitter systems treats only one dimension of these disorders. Non-pharmacological therapies that aim at altering one's thought and behavior operate on the recognition that beliefs, emotions, and other mental states are inseparable from the social and natural world in which one is embedded as a human subject.

All psychiatric disorders have a neurobiological underpinning.

But they are not *just* neurobiological. The reductionist claim that these disorders can be explained entirely in neurobiological terms may give us de-stigmatization at the cost of de-personalization (Fuchs, 2004). Emphasis on impersonal brain mechanisms may eliminate feelings of guilt or shame in those with psychiatric disorders, as well as the tendency of others to blame individuals for having them. Yet by focusing on the brain rather than the person, biological psychiatry may lose sight of the fact that we are agents interacting with others and that our minds are essentially shaped by this interaction. As psychiatrist and philosopher Thomas Fuchs points out: "A reductionist biological concept of mental life may lead to a self-alienation: in the wake of a popularized neurobiology, we are beginning to regard ourselves not as persons having wishes, motives, or reasons, but as agents of our genes, hormones, and neurons." (Fuchs, 2004, p. 483) In this regard, biological psychiatry may have negative implications for free will. A neurobiological model that explains disorders of the mind entirely in terms of brain mechanisms may strip persons of their autonomy and agency. It can weaken the conviction that persons have the capacity to regulate and guide their mental states to intended actions and thus be the authors of their behavior. Such a model can undermine the belief in self-determination by reinforcing a learned helplessness and the belief that all of our thought and behavior is controlled by the brain. Rather than support the idea that persons can be effective agents in the world, biological psychiatry risks giving us the idea that everything we do is at the will of the brain. Whether it is pathological or normal behavior, one may be left with the idea that "my brain made me do it" (Gazzaniga, 2005, Chapter 5)

Responding to Francis Crick's reductionist claim that we are "nothing but a bunch of neurons" (Crick, 1994, p. 3), neurobiologist Steven Rose expresses the same conception of the brain-mind relation that I have outlined:

"We" are a pack of neurons, and other cells. We are also, in part by virtue of possessing these neurons, humans with agency. It is precisely because we are biosocial organisms, because we have minds that are constituted through the evolutionary, developmental, and historical interaction of our bodies and brains (the bunch of neurons) with the social and natural worlds that surround us, that we retain responsibility for our actions, that we, as humans, possess the agency to create and re-create our worlds (Rose, 2005, p. 305).

Exclusive emphasis on the neurobiological basis of the mind fails to appreciate the extent to which the content and qualitative aspects of the mind are a function of factors both inside and outside the brain. There is no plausible conception of psychiatry, or indeed any area of medicine, that treats the person as nothing more than a self-contained biological entity. A holistic view of the mind as distributed among the brain, body, and environment, where the brain is a relational organ that mediates interaction between the human subject and the environment, provides the best model to guide interventions that will have the most salutary effects on the brain and the mind. Such a model can help to reduce the social stigma associated with psychiatric disorders and retain a robust sense of personhood and agency necessary for these effects to be realized.

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## Is Deinstitutionalization a 'Failed Experiment'? The Ethics of Re-institutionalization

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### Introduction

For the last 40 years British Columbia has pursued a general policy of deinstitutionalizing patients from its one large psychiatric hospital, Riverview Hospital (RVH), to a variety of alternative, community-based living and care-giving arrangements. This policy has not unfolded in a systematic, linear fashion, but rather it has been punctuated by interruptions and delays as policy makers and mental health care managers have tried to balance public fears and misperceptions that mental illnesses are linked to violence and the growth in homelessness, with the need to provide shelter and treatment to people with mental illnesses while maintaining their civil liberties.

Currently, the province is in the midst of implementing a major plan to close RVH, replacing it with various other facilities and services, and establishing a full spectrum of care across the province in a newly-decentralized health care system. Ironically, this process is being challenged even as it enters its final phases. As evidence is beginning to emerge about the successes of deinstitutionalization in the province (Lesage, Groden, Ohana, Goldner, 2006) and the processes related to downsizing RVH (Morrow, Pederson, Jamer, Battersby, Josewski & Smith, 2009), the political tide has changed due to pressures related to the visibility of homelessness, addictions and poverty in downtown Vancouver, and the link between these social problems and psychiatric deinstitutionalization in the public and popular imagination. The result has been increased

calls for re-institutionalization, particularly from some key community leaders. Using BC as an illustration, this paper reflects upon some of the current ethical issues arising from calls for the re-institutionalization of people with chronic and persistent mental health challenges.

Calls for re-institutionalization reflect the historic tension between providing support and imposing control on people with mental health challenges, as well as public understandings of the nature of mental illnesses, their treatment and their impact upon the community. Further, in the current neo-liberal context of mental health reform and welfare state restructuring, re-institutionalization is attractive to policy makers and community leaders seeking to make homelessness and poverty in urban centres less visible. Indeed, because neo-liberalism justifies policies and programs that emphasize individual responsibility and bio-medical explanations of mental illnesses over social and systemic analyses, it contributes to a climate of opinion in which calls for re-institutionalization are not easily contested.

As health care providers and researchers we must be wary of policy directions that could result in greater restrictions on people who use mental health services as opposed to providing them with better supports to live full and rewarding lives. Specifically, we can contribute to public policy discussions by providing evidence on the impact of various responses to people with mental illnesses and remain cognizant of the tensions between support and control that

arise in providing care. In this paper, we will challenge the ethics of the call for re-institutionalization and policy making that is reactive and not supported by evidence. It is our contention that the rights of persons with mental illnesses to the most life-enhancing supports are potentially undermined by the development of new facilities and initiatives that enforce treatment and constrain individual freedom in the name of community safety.

## The Current Situation: De, Re or Trans Institutionalization?

Psychiatric deinstitutionalization began in Canada in the 1950s with a shift of care from public mental hospitals to community mental health services (Shera, et al., 2002; Moran, 2000, Lesage, 2000). Deinstitutionalization was, and continues to be, driven by a number of interconnected forces including developments in psychopharmacology, new psychosocial rehabilitation practices, studies of the negative impact of institutional life, concerns about the civil rights of people with mental illnesses and cost-containment (Lesage, 2000). Some of the early assessments of psychiatric deinstitutionalization produced in the 1960s, 1970s and 1980s reported on the negative aspects of the process, particularly the deterioration of people leaving institutions (Krupinski, 1995). Critics argued that governments had failed to fund adequate community supports for people with mental illnesses trying to reintegrate into communities (Dear & Wolch, 1987; Rose, 1979). Deinstitutionalization also made people with mental illness more visible as the closing of large hospitals made the sources of a person's care less visible.

In some instances, deinstitutionalization has meant the shift of beds from large psychiatric institutions to the back wards of hospitals and/or the application of institutional treatment models characterized by paternalism and coercion in community settings; that is, one could argue that the institution has not disappeared but rather changed location. Trans-institutionalization has been further observed in research that documents the criminalization of people with mental illnesses after leaving institutional psychiatric care (Fazel and Danesh, 2002), such that people with mental health problems are institutionalized in corrections facilities rather than treated in hospitals or other health care facilities.

In BC, proposals to phase out RVH have been made periodically since the late 1960s, coinciding with welfare state restructuring and deinstitutionalization trends in other Canadian, North American and European cities (Skull, 1994; Rose, 1979; Quinn, 1996). The majority of beds at RVH were closed between the years of 1956-1976. RVH had reached its peak bed capacity in 1956 with 4,036 beds; these had been reduced by more than half by 1976.

British Columbia is an interesting case for studying mental health care because it is undergoing a final phase of deinstitutionalization in a particular historical context. The current phase of deinstitutionalization began with the 1998 *BC Mental Health Plan* (BC Ministry of Health 1998). The *Plan* called for regional self-sufficiency for mental health services through the devolution of tertiary resources from RVH to regional health authorities (BC Ministry of Health, 1998). The creation of regional health authorities began in 1996 and, though it too has undergone successive organizational forms, continues to be the formal organizing mechanism

for health care in the province. The "Riverview Redevelopment Project" began in 2000 and focuses on relocating RVH's remaining occupants to cities and towns throughout BC and distributing resources for the care of people with chronic mental illnesses more widely than previously. The province has developed 396 replacement beds and currently approximately 245 people remain at RVH, although some health authorities have completed the process such that there are no remaining patients from that authority at RVH. Bearing this phase of deinstitutionalization in mind, it is perhaps appropriate to describe the current situation of most people in BC with serious mental illnesses as one of trans-institutionalization as all people leaving RVH are transferred, at least initially, to other (often smaller, more pleasing) facilities that are nevertheless still characterized by institutional routines and treatments.

While the vast majority of people with mental illnesses are not institutionalized, 10-20% are in hospitals or supervised settings, and people with severe and persistent forms of mental illness typically require comprehensive forms of treatment and support. Currently, a substantial proportion of the mental health care budget is directed toward people suffering from serious mental illnesses rather than the large number of people with less serious problems. Moreover, despite medical management, some people with mental illnesses continue to express socially marginal behaviour, raising questions in the public mind about the effectiveness of current housing arrangements and medical care.

Among the political responses to the visibility of mental illness in BC has been the opening of a new 100 bed facility for people with mental health and addictions and the establishing of Vancouver's Downtown Community Court (British Columbia, 2008; CBC, 2006 & 2008). While those working in mental health have welcomed such new resources and approaches, they could impede people's recovery if these facilities simply mimic the traditional care provided in institutional settings and if no additional, comprehensive supports are provided. What is needed is a continuum of care which recognizes that housing and other social welfare supports are key to managing and recovering from mental health (and substance use) problems.

Historical accounts of institutionalization and deinstitutionalization typically describe these processes as linear and progressive yet the evidence from BC is that the processes are cyclical rather than continuous, with various phases of deinstitutionalization occurring over the past 40 years. Psychiatric hospitals serve both manifest and latent functions (Lesage, 2000; Henderson & Thornicroft, 1997; Moran, 2000). Manifest functions of psychiatric hospitals include, for example, the provision of treatment for both short to intermediate stay patients, custody for long-term patients, the desire to protect people who are vulnerable, respite for family caregivers and secure provision for involuntary and assaultive patients. Latent functions, in contrast, may include job security for professional staff, segregation from society of people who are understood as 'deviant' or dangerous (Henderson & Thornicroft, 1997) and political solutions to problems with the visibility of people who are mentally ill and homeless.

How society cares for people with mental illness reflects its social and economic tensions and highlights that care occurs, not only in a medical, but also a political context. Thus, there have consistently been ebbs and flows regarding society's tolerance for deinstitution-

alization and the visibility of people with mental illnesses. Calls to re-institutionalize people are rarely based on research evidence and instead garner support through editorials and sensationalized media reports of people with mental illnesses as violence and unpredictable (Krupinski, 1995, *The Province*, 2006). Commentators point to the numbers of people in prison or erroneously to the numbers of people on the street with mental illnesses. Missing from the public dialogue is a discussion about what is known about how best to meet the comprehensive needs of people with mental illnesses, needs which include housing, income security, access to meaningful activities and other social rights.

## Re-institutionalization and the Ideology of Neoliberalism

The Riverview Redevelopment process in BC has occurred in a context of dramatic health and social welfare restructuring. Starting in the mid-1990s, the health care system has undergone successive waves of decentralization and restructuring—including regionalization. In 2001, a newly-elected BC Liberal government initiated the rapid amalgamation of what were then 52 health authorities into five geographic and one provincial health authority (plus the Nisga'a Health Board). This restructuring introduced new fiscal pressures and changes to the mechanisms designed to involve mental health care recipients in decision making. Simultaneously, changes to social welfare supports and disability pensions, the divestment of federal funding from housing and a general retrenchment of social welfare services has resulted in increased poverty and homelessness, most visible in Vancouver's downtown eastside (Klein, Pulkingham, Parusel, Plancke, Smith, Sookraj, Vu, Wallace & Worton, 2008; Morrow, Frischmuth & Johnson, 2006). The trend increasingly in this context is to expand the definition of mental illnesses to encompass people who are poor and homeless. This feeds directly into the uncritically accepted idea that deinstitutionalization, in and of itself, has increased homelessness (Mossman, 1997).

Additionally, the hosting the 2010 Winter Olympic and Paralympics Games in Vancouver has created a political climate in which the visibility of people dealing with homelessness, addictions and mental illnesses is currently in the public consciousness. A fixed election schedule for the provincial legislature, introduced in 2001 with the next scheduled for May 2009, also means that politicians are keenly aware of the need to be addressing the problems of the visibly distressed in the province's largest city.

Neoliberalism as a dominant public discourse and state modality favours reduced government (Kingfisher, 2002; Peck and Tickell 2002) and reduced social expenditures on social assistance and public programs (Raman 2008). Further, neoliberalism fosters a belief in economic individualism and a reduced role for the state in economic regulation and social support. Neoliberalism emphasizes individual responsibility to address social problems and, as such, supports individualistic models for understanding mental health and illness (Galvin 2002). As Ramon (2008) has observed in the UK, the mental health system in Canada, functions as a hybrid of liberalism, neoliberalism and social democracy. In the UK context, Ramon argues that "this co-existence leads to tensions, contradictions and to swinging from one direction

to another depending on specific constellations of interests and power operating at a given time." (p.118). In BC these swings are evident in the dramatic shift from a social democratic approach to mental health under an NDP government (with a focus on citizen engagement, protecting rights, advocacy and community based supports) and the BC Liberal regime where cost-cutting and cost efficiencies have been paramount in the organization and delivery of health care services (Morrow, et al., 2006).

Although Canada has avoided the dominant conservative paradigm of the United States in which the state's duty to impose law and order can be an explicit and decisive factor in political debate, an implicit desire for policies that promote order and security may drive mental health care planning decisions that push for a lower bar to force inpatient care on individuals with mental illness. When this is overtly seen as a medical intervention for someone who is ill – a benevolent act by the state to provide care to someone who does not know better – it may feel more acceptable than the unspoken social control that may underlie this.

## Medical Versus Social Explanations of Mental Illness

Prior to the 19th century, attempts to understand or explain mental illnesses involved either magical or religious explanations such as demon possession or biophysical explanations. Moral treatment models in the 19th century recognized the role of environmental influences on hereditary influences and thus focused on manipulation of environmental factors as part of treatment (Colp, 2004).

Although initially working from a biophysical model that invoked structural and functional (physiologic) forces, Freud precipitated an explosion in interest in psychological explanations of illness that became the dominant paradigm in psychiatry. Even though psychiatric practice continues to emphasize the role of the biopsychosocial formulation in understanding people with mental illnesses, the reaction to psychoanalytic thought has further driven the dominance of biomedical paradigms that are reductionist in their de-emphasis of the psychological and sociological contributors to illnesses. Indeed, the period in which deinstitutionalization occurred parallels the shift to a biomedical paradigm to the point that "neuroscience can justifiably be considered the biomedical foundation of psychiatry" (Hyman and Cole, 1996, pg. 3).

The resultant increasing focus on mental illness as an 'illness' with neurobiological causes and underpinnings has also had beneficial results. It has helped promote the development of new treatments, it has helped reduce the stigma that may arise as a result of magical or religiously determined theories of mental illness and it has encouraged investment in research, treatment and care. Indeed, concern about stigma and its impact on people with mental illness has been increasingly addressed through public education campaigns that equate mental illness with any other illness of the body.

At the same time, by defining mental illness as an 'illness', a set of expectations has been created that may be unrealistic even for those illnesses that best fit the biomedical model of causation. Implied within this model is that there is a specific biological cause that

in turn requires a specific treatment to produce a cure. Applying this overly simplistic explanation to mental illnesses does allow optimism about treatment, but also encourages an interventionist approach that does not easily handle an individual's refusal of treatment for example. Traditional models of public health including the use of imposed treatment are easier to justify within this linear model. Ethically a conflict can be established between the right to choose versus the right to be well. The biomedical model has also fostered expectations of the 'good patient'. Indeed, Parson's (1951) construct of the "sick role" is premised on an acute model of illness in which the patient submits to medical intervention, separates themselves from the mainstream social order temporarily, and is expected to try to get well. Chronic illness generally, including mental illness, does not fit well within this model nor with its expectations of the patient.

In the minds of many people, the focus of medical treatment, especially for those who are severely ill, is the hospital. Under this model, the more ill the person, the more likely they are to need and benefit from the hospital. Hospitals provide a reassuring presence that is both highly visible and extremely tangible, and may for many epitomize care. It is hard then to understand that there are illnesses that may worsen in hospital, or may be severe and yet not require hospital care, as is often the case with mental illnesses. Although we are now increasingly recognizing that in fact hospitals can be dangerous places because they are reservoirs of infection (e.g., for MRSA or *c. difficile*), they often play an important role in assuring us that care is there when we need it. Thus, when confronted with the sometimes unusual behaviour of a person with a mental illness, the immediate assumption made is that the individual concerned must need care in a hospital, and that their presence outside of the hospital is evidence of some kind of failure of delivery of health services. The behaviour in fact may be a result of many things and may have nothing to do with that person's relative recovery or functionality (Mossman, 1997). The individual may in fact be involved in extensive community care, but their presence in public is often interpreted as a failure of the "hospital", which traditionally in many places in mental health care was the institution.

At the same time, as we have expanded our awareness of neurobiological contributions to many forms of mental illnesses, we have expanded the definitions of mental illness, often moving along continua of normal behaviour or experience. Social phobia has received increasing attention as medications such as the serotonin specific re-uptake inhibitors (SSRIs) have been shown to reduce symptoms to the point that the separation between this illness and the trait of shyness has become blurred. Similarly, as we have learned more about people's responses to trauma we have developed an expanded list of psychiatric conditions to describe this reaction, from 'Post Traumatic Stress Disorder' to 'Acute Stress Disorder' to 'Adjustment Disorder with Anxiety or Depressed Mood'. It becomes harder and harder to know what is illness and what is a normative response (Morrow, 2008). The blurring of the boundaries between what is an 'illness' and what is a normative response has consequences both for a treatment system that now assumes responsibility for care for a broader spectrum of problems, and also for individuals for whom a trait or characteristic that may not be particularly disabling or distressing, gets labelled as an illness, with resultant pressures to accept treatment.

One of the places in which these tensions play out in the BC context is in efforts to address the visible distress on the streets of Vancouver's downtown, where there is the highest concentration of poverty, homelessness, addictions and mental illnesses at the same time that the social welfare state has been dramatically diminished and the province is positioning itself to address the barrage of local and international media attention leading up to and during the 2010 Olympics and Paralympics that will shine a spotlight on visible social problems, as described earlier. In this context, advocates are hopeful that the increased attention might help all levels of government cooperate to address the complexities of service and support needs. Certainly, the very visible distress on the streets of Vancouver puts pressure on politicians at all levels to address the situation. In this context it is easier to understand mental health and addictions as strictly medical issues with individualized bio-medical solutions, rather than the complex, multi-faceted problems that they are.

The growth in homelessness in much of the western world that has occurred over the 1980s and 1990s (Neito, Gittelman & Abad, 2008) has often been blamed on the de-institutionalization of individuals with severe mental illnesses, even though the bulk of the deinstitutionalization predated that era (e.g., the majority of RVH's beds were closed between 1956-1976). Although the link between homelessness and mental illnesses would appear to be supported by studies that state that the majority of people who are homeless have an increased lifetime chance of being diagnosed with mental illness, in fact estimates of prevalence of severe mental illnesses such as schizophrenia have been shown to be in the range of 11-17% (Bonin, Fournier & Blais, 2007). Given that people with schizophrenia are often living in poverty as a result of lack of affordable housing and disability benefits well below the poverty line (Cohen, 1993), and that poverty is a major factor in homelessness, it is not surprising that there is an elevated rate of schizophrenia in this population. At the same time, Toro, Bellavia, Daeschler, Owens, Wall, Passero and Thomas, (1995) showed no increase in the diagnosis of schizophrenia in a homeless sample compared to a sample of never-homeless poor. Clearly the growth in the visibly homeless that we have witnessed in Canada cannot be explained by the proportion of individuals with schizophrenia who would previously have been institutionalized. At the same time, by providing a diagnosis for the majority of people who are homeless, and ignoring causality (i.e., the impact of homelessness on mental illness and stress), society is provided with a relatively simple explanation and solution for the complex problem of homelessness. By this logic, improving treatment and availability of treatment for mental illnesses, and targeting that treatment to those who are homeless and mentally ill, will solve the problem of homelessness. The definition of the problem as medical allows society to respond in a paternalistic way by imposing treatment, a more acceptable response than imposing social controls on people who are not defined as ill.

The problem is not whether or not one uses a biomedical model to understand mental illnesses, as the use of such a model is often quite valuable, whether it be to reduce stigma or improve treatment. The issue becomes the assumptions that are often triggered by such a model that can include a switch to paternalism and imposed care, a re-definition of a complex social problem (homelessness) as a medical problem with medical solutions, and the reactive use of traditional medical models of care such as

hospitalization, even when they may not be appropriate.

## Support Versus Control

A persistent tension between the provision of support and the imposition of social and medical control permeates policy making and care-giving with respect to mental illnesses. Issues of support and therapeutic intervention on the one hand, and control of people with mental illness on the other, have been intertwined since the earliest days of the asylum movement. During the development of the asylums in the 19th century, the actual physical locations chosen for the facilities were often those which would allow the removal of people with mental illness to supposedly more healthful environments outside of urban centres (Fakhoury & Priebe, 2007). While often offering those with mental health challenges quiet surroundings, these locations served the secondary purpose (or latent function) of removing people who were deemed undesirable from more general society (Leff, 2004). Similarly, while the asylum offered support with respect to shelter and sustenance, the actual daily life of the asylum was dictated by administrators and medical staff, not those receiving care.

Although cycles in institutionalization have occurred for centuries, the current cycle, which began in the late 1950s in most western countries was characterized by a shift in the direction of autonomy for people with mental illness, as opposed to prior cycles in which primary motivations were benevolence and paternalism in conflict with desires to control or remove “undesirables” (Fakhoury and Priebe, 2007). The psychiatric survivor movement, in conjunction with allies in various mental health professions, harshly criticized traditional psychiatric care and especially forced treatment, ushering in a new era where the rights of people with mental illnesses to determine their care and access other social rights (e.g., housing and income) became paramount (e.g., Barnes & Bowl, 2001; Chamberlin, 1978; Morrow, 2007). However, these rights are still precarious in the face of a system that continues to support biomedical approaches over social and systemic ones. Critiques of deinstitutionalization (Krupinski, 1995) and the lack of government support for community based mental health supports, has unfortunately kept the door open for arguments, couched in the language of care, that certain kinds of forced treatment should be supported. The question to be addressed though is to what degree this desire for care disguises a desire to better control people who may be, by their appearance or actions, disruptive in society?

## Discussion

The tensions we have described within mental health policy and care are not unique to Canada. A recent report from the World Health Organization that surveyed mental health services in 42 countries in Europe states:

Many countries are reducing the numbers of beds and are moving towards closing mental hospitals to replace such institutional forms of care with community-based mental health services. Strategies are therefore especially important to communicate the underlying change in values. Community-based services place great emphasis on people's

autonomy and providing care that is based on the needs of the individuals and sensitive to their life experiences and culture. Strategies have to reflect this. Further, introducing community-based services considerably changes the rights, duties and protection of individuals, families, staff and the community. High activity in policy-making and legislation can therefore be predicted in the WHO European Region (WHO 2008, p. 11).

As clinicians and researchers, we have a role to play in addressing the issues of social inclusion and exclusion that arise for people with mental illnesses and work to ensure that actions are taken beyond the boundaries of traditional health care to provide the care and support people with mental health challenges are entitled to receive. Anti-stigma campaigns, currently in vogue as strategies for fostering social inclusion, will not be sufficient in themselves to address the persistent tension between support and control that underlies mental health care. Strategies that ensure the representation of service users in the development of programs, facilities, and policies with respect to mental health care—and which foster interaction between those diagnosed as mentally ill with those not so diagnosed—could contribute to greater social understanding of the experience of mental illness and ensure that services are acceptable to users. In discussions of re-institutionalization in BC, the voices of those with mental health challenges have been largely absent to date.

Similarly, the expanded understanding of the brain that has arisen as a result of a focus on biomedical causation models in mental illness needs to be balanced by continued attention to broader determinants of mental health and wellness. Biomedical domination of services and supports must be resisted and governments must be held to commitments to provide funding for housing and other social supports that will increase the economic and social security of people with mental illnesses. Finally, the importance of gathering evidence on what supports and services work best for people with mental illness cannot be over-stated. Recent opportunities to study supported housing approaches for people with mental illness, being offered through funding from the Mental Health Commission of Canada for a series of demonstration projects in Canadian cities (including Vancouver)<sup>iii</sup>, is one such opportunity.

Large public events such as the approaching 2010 Olympic and Paralympics Games in Vancouver have resulted in a greater attention to social issues in the province, as awareness grows of the international scrutiny these games will bring. If this scrutiny results in a sophisticated analysis based on evidence of the many issues involved in such challenges as homelessness, involving an inclusive approach to problem analysis and solution development, the games can catalyze social change. If, however, the approach focuses on an agenda that seeks rapid and simplistic solutions imposed from the top, be it by government or by health care authorities, the result may be an expensive and ultimately ineffective set of solutions that increasingly challenge the autonomy of people with mental illnesses in the province.

1 In 2006 BC's Premier Gordon Campbell in a speech to the union of municipalities said, "We're going to listen to what we've heard from you, and you know what you've told me - de-institutionalization is a failed experiment."

1 Recent civic elections in Vancouver (November, 2008) saw the Vision Party, who had reducing homelessness as one of their key platforms, sweep to power.

1 The Mental Health Commission of Canada has allocated \$110 million to support homelessness demonstration projects focused on people with mental illness in Vancouver, Toronto, Montreal and Moncton. 85% of the funding will go to housing and 15% to research on its effectiveness.

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#### **Competing Interests :**

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## The Delicate Dance in Canadian Mental Health Policy: Balancing Equality Rights, Family Rights and Community Rights

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In 1987, two criminologists from Simon Fraser University claimed that, unlike the United States where there had been landmark federal mental health law cases, there had been no Canadian cases establishing constitutional rights to treatment, to refuse treatment, or to receive treatment in the least restrictive environment (Gordon and Verdun-Jones, 1987: 190). Since that time, there have been several important cases that have involved the issues of consent and capacity. There have been several precedent-setting cases in Ontario including *Fleming v. Reid* and *R v. Swain*. Briefly stated, both decisions weakened the authority of physicians and psychiatrists as well as several Charter rights, including freedom of thought according to some critics (Gray et al 2000).

Despite the fact that section 15 of the Canadian Charter of Rights and Freedoms formally recognized and entrenched equality rights for individuals with physical and mental disabilities, the justice system has struggled with cases that have attempted to 'frame' mental health practices as equality issues. This article will focus on a case that went all the way to the Supreme Court of Canada that ultimately was argued on the basis of personal autonomy to make decisions centred on the issue of treatment.

Patients in psychiatric facilities had virtually no say in their treatment until the past twenty years or so. The 'voice' for change in how the mentally ill were treated emerged largely due to several factors including the rise of the civil rights movement(s) in the 1960s and 1970s, the eventual entrenchment of the Charter of Rights and Freedoms within the Canadian constitution, and the rise of the consumer movement. In part, the consumer movement was initially driven by the recognition that radical treatments such as insulin-induced comas, lobotomies and shock treatments were used haphazardly with little regard for the patient in the post-World War II era. Oftentimes, the justification was that the treatment calmed the patient which ultimately made life easier for the medical staff (Simmons 1990).

More recently, there has been a heated debate about involuntary outpatient commitment (IOC). Opponents of IOC argue that the use of this tool was born out of stereotypes associated with mental illness. Despite statistics to the contrary, many fear that mentally ill people are dangerous. There is also a strong belief that forcing the mentally ill to take medication will somehow cure them. However, many of these drugs have powerful side effects. In December 2006,

the New York Times ran a series in which they claimed that drug maker Eli Lilly had engaged in a ten-year effort to play down the health risks associated with Zyprexa, the leading selling medication for schizophrenia. A lawyer representing mentally ill patients had obtained documents and email messages exchanged among top company managers that contained information from doctors related to Zyprexa's links to obesity and its tendency to raise blood sugar – both known risk factors for diabetes (Berenson 2006). The American Diabetes Association, among other critics, claimed that Zyprexa, which was introduced in 1996, was more likely to cause diabetes than other widely used schizophrenia drugs. In 2005, Lilly agreed to pay \$750 million to settle suits by 8,000 people who claimed they developed diabetes or other medical problems after being prescribed the drug (Berenson 2006).

### The Consumer Movement, The Charter and Equality Rights:

As the mental health system in Canada currently works, capable psychiatric patients – those who are considered able to appreciate the foreseeable consequences of accepting or refusing treatment – have the right to make that treatment decision for themselves, whether they are voluntary or involuntary patients (Sklar 2007). As stated by Sheila Wildeman: "The right to make treatment decisions is a basic tenet of health law in Canada and internationally" (Wildeman 2006, 232). Because consumers typically have few material resources and are largely disempowered, advocates of the mentally ill claim that issues of freedom and liberty are extremely important to this population. In particular, because the mentally ill are oftentimes involuntarily admitted to psychiatric facilities, these rights become even more cherished. In Canada, it was not until the early 1970s when patients' rights groups began to mobilize. Mental health consumers organized On Our Own in the late 1970s and established the magazine quarterly Phoenix Rising (Simmons 1990). Other groups included Concerned Friends of Ontario Citizens, the Advocacy Resource Centre for the Handicapped (ARCH) and the Disabled Women's Network (DAWN). One of the policy responses to this negative press was the establishment of the Patient Advocate Program in 1982 in Ontario. The program became operational in May 1983 with the appointment of 11 patient advocates. The mandate of the program was to advance the legal and civil rights of psychiatric patients who were residents of the province's psychiatric hospitals. Other provinces

also established comparable watchdog organizations.

Like members of other illness groups, the psychiatric consumer/survivor rights movement mobilized when former patients began to realize that they had been denied basic legal rights and had been discriminated against because they were mentally ill. Many shared feelings of disenfranchisement and powerlessness in being institutionalized through involuntary commitment and forced treatment. In this important sense, early consumer/ex-patient groups “rejected the medical model of mental illness, professional control and forced treatment and [sought] alternatives exclusively in user controlled centers” (McLean 1995, 1054). Other consumers were more accepting of the medical model of mental illness and traditional treatment practices including medication adherence. Although these individuals came from diverse backgrounds and had somewhat different perspectives regarding the mental health profession, their common experience became the rallying mantra of this new social movement (Frese and Davis 1997). The issue of the right to privacy of persons living with mental illness and the impact of that right on their family caregivers has been contested. After hearing from consumers and caregivers, the Kirby Commission’s Final Report – Out of the Shadows at Last clearly spelled out the dilemma.

With respect to privacy and confidentiality issues, the Committee is well aware that any erosion of privacy and confidentiality protections can have serious negative consequences on an individual’s trust in his or her caregivers. However, . . . witnesses have told us that rigid adherence to privacy and confidentiality rules in certain circumstances can work against the interests of individuals whose mental health is compromised. The unique challenges they describe must be recognized when developing, interpreting and applying privacy and confidentiality rules, so as to allow health care providers and family caregivers to provide patients with the much needed support they sometimes require (Standing Senate Committee on Social Affairs, Science and Technology. Report 1. 2004, 246).

As is the case with all Canadians, people with a mental disorder have the right to be notified of their legal rights under the Charter including notification of why they are being detained, the right to counsel and have the validity of the detention determined by way of habeas corpus. Involuntary patients also have rights under provincial mental health acts including the right to apply to a tribunal such as a Review Board or a Review Panel (Gray et al 2000).

Section 15 (1) of the Charter of Rights and Freedoms states that: Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age, or physical or mental disability. By specifically including mental disability as a recognized ground of discrimination, the Charter established the federal government as the champion of the rights of persons with a psychiatric disability and dictated that the federal and provincial governments were obligated to protect and promote equality rights (Torjman 2001). Provinces were given three years to bring their statutes into line with the Charter. In Ontario, Bill 190 was finally passed in June 1987 after considerable debate. The original version

of the Bill gave boards of review an override power which was supported by psychiatrists and the medical community. Viewing this as a draconian measure, psychologists, social workers, advocates and patient self-help groups were opposed (Simmons 1990). According to Bill 190, competent involuntary patients had the right to refuse treatment. However, a board of review was given the authority to override the decision of a substitute decision-maker to refuse treatment for involuntary incompetent people.

Even if individuals are involuntarily admitted to a psychiatric ward, they still have their Charter rights. Provincial mental health acts also grant involuntary patients additional rights and safeguards. These rights and safeguards include:

- committal criteria and procedures;
- treatment authorization criteria and procedures;
- rights information;
- renewal certificates;
- review boards;
- the courts; and
- other safeguards (e.g., confidentiality). (Gray et al 2000)

As it relates to involuntary hospitalization, all Canadian jurisdictions permit involuntary admissions for persons who present a danger to themselves or to others. Generally speaking, provinces have tended to adopt either dangerous or treatment models of civil commitment. Some provinces contend that the danger must be of physical or bodily harm. Defenders and supporters of the dangerous model argue that restrictions on a person’s physical liberty and autonomy is only justifiable on the basis of the harm principle. In their view, any other justification is nothing short of discriminatory. Critics of the treatment model – that doctors know best as it relates to treatment – view this model as a paternalistic approach in dealing with mentally ill individuals (McLachlin 2005). However, some provinces go beyond the confines of the dangerous model.

In [other provinces] a broader notion of danger is used and the risk of serious mental, emotional, social or even financial harm may justify forced hospitalization. Some Canadian jurisdictions have also gone beyond dangerousness as the sole justification for involuntary admission. For instance, in British Columbia, Saskatchewan, Manitoba and, to a lesser extent, Ontario, a mentally ill person may be involuntarily admitted to prevent substantial mental or physical deterioration (McLachlin 2005, 21).

### The Starson Case:

Briefly stated, Scott Schutzman was an individual who legally changed his name to Scott Starson in 1993 (because he believed he was the son of the stars) and preferred to be called Professor Starson. He had a history of mental illness dating back to 1985. He was diagnosed as having bipolar disaffective disorder and, over the years, had an estimated fifteen hospitalizations both in Canada and the United States. He graduated from Ryerson Polytechnic University with a degree in electronic engineering and worked at several jobs including a sales job with an instrumentation company. However, his intellectual interest was physics and he developed several significant connections in the academic community as well as writing several scientific papers. He co-authored a refereed

journal article with Pierre Noyes, director of the Linear Accelerator Centre at Stanford University in California, who described Starson as being ten years ahead of his time (Tyler 2003). However, Starson has not published since 1995.

Starson had a run-in with the Toronto police in 1998 and was charged with uttering death threats to several of his neighbours in the apartment building where he resided. In November of that year, he was found not criminally responsible on account of mental disorder (NCRMD) and in January 1999, the Ontario Review Board (ORB) ordered him detained for twelve months at the Centre for Addiction and Mental Health (CAMH) in Toronto. Two psychiatrists (Dr. Ian Swayze and Dr. Paul Posner) at the CAMH prescribed a combination of mood stabilizers and anti-psychotic medications for Professor Starson but he refused treatment. On 20 January 1999, the Consent and Capacity Board (CCB) concluded that Starson was almost in complete denial of his mental illness and was not capable of making his own decisions about treatment. The Board also concluded that it was in his “best interest” to take medication. The phrase “best interest” would prove to be significant as the case unfolded.

The legal test for determining whether a person is capable of making his or her own treatment decision is found in section 4(1) of the Health Care Consent Act, 1996 (HCCA). It is a two-part test. Under this section, a person is “capable with respect to treatment” only if:

1. the person is able to understand the information that is relevant to making a decision about the treatment; and;
2. the person is able to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.

The HCCA allows CCB decisions to be appealed, which Starson did, and the case came before Madam Justice Molloy of the Ontario Superior Court. It is important to note that s. 4 of the Act presumes that people are capable; therefore, the onus is on the appellants to demonstrate that a person is incapable. On 26 November 1999, Molloy concluded that the Board’s finding was unreasonable and set it aside. In her view, the psychiatrists did not offer any compelling evidence that any of the drugs previously administered to Starson had ever been effective. She also claimed that the Board’s conclusion that Starson completely denied his mental condition was a “fundamental error.” Moreover, according to the legal decision, the CCB did not confine itself to the legal tests and made a subjective determination relating to the “best interest” of the individual which was beyond the scope of the CCB.

Drs. Posner and Swayze appealed Judge Molloy’s decision on the grounds that she misapplied both the standard of review and the statutory test in section 4 (1). Once again, the Ontario Court of Appeal, by a vote of 3-0 upheld the lower court’s finding that Starson was capable of making a decision regarding his treatment. According to their decision, the Court found that Starson did acknowledge that he had mental health issues and found that his reason for refusing treatment - a reduction of his cognitive abilities - was a reasonable ground on which to refuse treatment. In addition, the psychiatrists could not guarantee that the proposed medication regimen would be effective. Subsequently in the Supreme Court case, the *Amicus Curiae* stated that the Court of Appeal’s decision was important because it “sent a message to

psychiatric boards that they can’t always take a ‘paternalistic’ approach to patient treatment” (Tyler 2003). At the same time, family based organizations such as the Schizophrenia Society of Canada and its provincial arms were not happy with the decision. Starson’s mother was devastated by the Court of Appeal’s decision.

You know what the problem is? They didn’t include me. [My] son is a man of great potential suffering without treatment. He thinks he’s superman. He thinks he is the most brilliant person in the world. I adore my son, the man that is my son. He is truly such a good-natured, gentle, fascinating, beautiful person, but his illness has destroyed me. It’s been devastating (Tyler 2003).

By the end of 2000, Starson was transferred to maximum security at Penetanguishene. After another hearing, the Ontario Review Board (ORB) concluded:

While there is no evidence that Starson has been physically assaultive during his time in this facility, his ongoing barrage of death threats, insults and pending torture constitute potential psychological harm. To subject co-patients, whether in this facility or a less secure co-educational setting, to this kind of versatile flurry of assaultive behaviour is unwarranted. To allow Starson to suffer the consequence of an untreated mental disorder is likewise unwarranted (Spencer, [www.mdcanada.ca](http://www.mdcanada.ca): 22 October 2003)

It is interesting to note that this conclusion was made after Justice Molloy had ruled that Starson was capable of deciding whether or not to accept treatment. Many within the psychiatric community saw the last sentence as a parting shot at Justice Molloy’s decision. At the Penetanguishene facility, Starson continued to refuse treatment. Once again, a psychiatrist - Dr. Russel Fleming - appealed the decision of the Ontario Court of Appeal to the Supreme Court of Canada which heard the case in 2002 and delivered its decision on 6 June 2003. It is important to note that there were several intervenors in this case. Intervenors providing information and support for the appellant (Dr. Fleming) were the Centre for Addiction and Mental Health (CAMH) and the Schizophrenia Society of Canada - a family-based, non-profit federation organization that has provincial offices and local chapters. Intervenors that provided support for the respondent (Starson) were two pro-consumer groups - the Mental Health Legal Committee and the Mental Health Legal Advocacy Coalition.

Although the Starson case did not revolve around equality rights of the Charter, it was a case that galvanized the psychiatric community and pitted one individual and two consumer-based organizations against psychiatrists and several family-based organizations. As it relates to consumer-based groups, the Mental Health Legal Committee (MHLIC) is an organization of lawyers and community legal workers who represent consumers of mental health services. It was formed in 1997, and a number of its members appear regularly before the Consent and Capacity Board, among other agencies. The Mental Health Legal Advocacy Coalition (MHLAC), on the other hand, is a group of lay advocates in the field of mental health law. For the most part, its members self-identify as consumers/survivors of mental health services. Both of these groups supported the decisions made by the two lower courts in the Starson case and argued that the Board not only misapprehended the evidence but also misapplied the test for capacity. As such, these groups

claimed that its decision was unreasonable in fact and incorrect in law (MHLC and MHLAC, 2002: 2). These groups argued that by basing its decision on the concept of 'best interests,' the Board erred in applying the test for capacity. According to their factum: "it presupposes the existence of universally accepted values respecting human endeavour and mental wellness. It shuns diversity and, ultimately, incites paternalism" (MHLC and MHLAC, 2002: 3).

In the opinion of MHLC and MHLAC, capable individuals have the right to take risks and are presumed free to make decisions that are considered unreasonable. They pointed to the decision made in an earlier case involving the CCB when the Honourable Mr. Justice Harris stated: [i]t is mental capacity, not wisdom, that is at issue here. The appellant...carries with her, like all citizens, the right to be wrong" (MHLC and MHLAC, 2002: 4). They also pointed to the decision in the Fleming v. Reid case as reaffirming the right to refuse treatment under the Charter.

Mentally ill persons are not to be stigmatized because of the nature of their illness or disability; nor should they be treated as persons of lesser status or dignity. Their right to personal autonomy and self-determination is no less significant, and is entitled to no less protection than that of competent persons suffering from physical ailments (MHLC and MHLAC, 2002: 4).

Although these pro-consumer intervenors presented the results of two studies that were quite critical of anti-psychotic drugs and acknowledged that there are some side effects associated with these medications, it is important to note that there are many research studies that point to a significant correlation between medication non-compliance and an increased risk of re-hospitalization, emergency room visits, symptom exacerbation and homelessness. In addition, many within the psychiatric community, the medical community, community-based mental health facilities and family educators, among other interests, are solidly within the camp of the treatment model.

### Supreme Court Decision:

In a split 6-3 decision, the Supreme Court of Canada upheld the lower courts' decisions and ruled that Starson did have the capability and capacity to determine his own treatment. Writing for the majority, Supreme Court Justice Major wrote:

Although the patient did not conceive of the condition as an illness, he was quite aware that his brain did not function normally. There was also no evidence that the proposed medication was likely to ameliorate the respondent's condition...The Board's conclusion that treatment would improve his chances at future review board hearings is entirely speculative (Starson v Swayze, 2003).

Justice Major believed that the legislative mandate of Ontario's Consent and Capacity Board was to adjudicate solely upon a patient's capacity. The Board's conception of the patient's 'best interests' was irrelevant to that determination (Starson v Swayze, 2003: para76). Therefore, like the lower courts before it, the Supreme Court took a highly legalistic position in admonishing the CCB

for overstepping their jurisdiction and role. Even if someone was making an unwise choice, this was their right. Justice Major stated: "The right knowingly to be foolish is not unimportant; the right to voluntarily assume risks is to be respected. The State has no business meddling with either. The dignity of the individual is at stake" (Starson v Swayze, 2003: para76).

Drawing on the work and research of D.N. Weisstub, Justice Major justified his decision by pointing to an historical failure to respect this presumption.

The tendency to conflate mental illness with lack of capacity, occurs to an even greater extent when involuntary commitment is involved, has deep historical roots, and even though changes have occurred in the law over the past twenty years, attitudes and beliefs have been slow to change. For this reason it is particularly important that autonomy and self determination be given priority when assessing individuals in this group (Weisstub, 1990: 16).

In the dissenting opinion rendered by Madam Chief Justice Beverly McLachlin, she concluded that the issue of determining capacity involves walking a fine line in balancing values.

The [Health Care Consent Act] confronts the difficult problem of when a mentally ill person may refuse treatment. The problem is difficult because it sets in opposition fundamental values which we hold dear. The first is the value of autonomy - the ability of each person to control his or her body and consequently, to decide what medical treatment he or she will receive. The second value is effective medical treatment - that people who are ill should receive treatment and that illness itself should not deprive an individual of the ability to live a full and complete life. A third value - societal protection - comes into play in some cases of mental illness. Where the mentally ill person poses a threat of injury to other people or to him or herself, it may be justified to impose hospitalization on the basis that this is necessary in the interests of public safety which permits courts and Boards to impose hospitalization on an accused person found not criminally responsible on account of mental disorder (Starson v Swayze, 2003: para 6).

Unlike the lower courts and the majority of the Supreme Court, the dissenting opinion concluded that the Board had not erred in its judgement. It reasoned that the absence of understanding and acknowledgement of his condition rendered Scott Starson unable to understand the factors relevant to making a decision about treatment. In addition, he was considered 'unable' to appreciate the consequences of lack of treatment. Far from being an error, the Board followed the accepted approach to ascertaining ability. As for the Board's preliminary expression of sympathy of concern when it invoked the language of medication compliance being in the patient's 'best interests' - this did not mean (in McLachlin's view) "that the Board focussed on the wisdom of refusing treatment rather than on Professor Starson's capacity" (Starson v Swayze, 2003: para 22).

The decision by the Supreme Court was highly controversial. On

one hand, survivor and consumer groups lauded the decision as a victory. Other groups such as the Schizophrenia Society of Canada lamented the decision claiming that the rights of families to have their loved ones treated for serious mental illnesses had been disregarded by the courts. Immediately after the decision, Starson's mother issued the following statement: "How can the Supreme Court hope to rule on a human being without having seen the person himself; without really and truly understanding the effects of his illness on his family and his society? It's beyond me" (Makin: 7 June 2003). Perhaps, though, the largest criticism came from the Canadian psychiatric community. Their concerns relate to the narrow legalistic view taken by the judges in assessing treatment decisions affecting the mentally ill. The purpose of the HCCA, they argued, is not to deprive people of their civil rights but rather to help people to get treatment when they are not able to make decisions on their own. As a result of this decision, mental health practitioners have suggested that the Health Care Consent Act should be amended to allow the Consent and Capacity Board to take a patient's "best interests" into account. The 'best interests' test is the one used in British Columbia, Saskatchewan and Newfoundland and, according to Gray et al, there have been no reported court cases in those jurisdictions that have challenged the authority of provincial boards. Another concern relates to the effectiveness of medication. How will the courts balance the opinions of psychiatrists - many of whom have their research supported by pharmaceutical companies - with the opinions of consumers and with the opinions of family members and the groups that represent their interests? As noted by Christina Spencer:

Doctors must make sure they lay out their case for incapacity - if they have one. They can no longer talk to the consent board in shorthand. Before Starson, the practical standard for the physician was merely, in Anita Szigeti's words, "that they had to show up." Now, more questions are being asked at consent hearings. Starson has probably helped future psychiatric patients (Spencer, mdcanada.ca: 22 October 2003).

In a number of legal post-mortems of the Starson decision, the fact that the Supreme Court did not rule that Starson's incapacity on the denial of his illness violated "principles of fundamental justice" within the meaning of Section 7 of the Charter has potentially opened the door to a future Charter challenge. In particular, in both the majority and minority opinions of the Starson case, reference was made to the capable patient's right as "fundamental" to his or her "dignity, autonomy and right to self-determination" - language that strongly suggests a positive decision by the Court under Section 7 of the Charter" (Sklar 2007, 394).

## Conclusions:

In many respects, the Starson decision reaffirmed the trend that individual rights of the mentally ill are being championed by the courts in the post-Charter era. However, as it relates to the rights of other interests in the area of mental health, the courts have found only a delicate balance. Family-based mental health advocacy groups, organizations such as the Schizophrenia Society of Canada and its provincial affiliates as well as the Mood Disorders Association are all attempting to ensure that families need to be treated as partners in the care of their family members. The language of

the final report of the Special Senate Committee on Social Affairs, Science and Technology clearly supports the claim that families must be considered as partners in Canada's mental health system. Families of individuals who refuse treatment are increasingly being forced to navigate a complex psychiatric and legal system in efforts to demonstrate that their family members are not capable of making treatment decisions. Although most mentally ill persons are not violent, there may be instances when they may present a significant risk of harm to themselves or others. In this important area, they may be a risk to public safety and may become mired in the criminal justice system. In the end, communities are picking up the costs for the long-term institutionalization of individuals where outcomes for recovery are reduced, not enhanced.

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# BENCHMARK

## Queue-Jumping?: Do Mental Health Courts Privilege Criminal Behavior?

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### ABSTRACT

Mental health courts, premised on the notion of therapeutic justice, have become an increasingly appealing way of dealing with what is widely, although not uniformly, seen as the inappropriate incarceration of people who engage in criminal behavior caused by mental illness. Nevertheless, mental health courts are not without their critics and a number of objections have been raised against the implementation of these courts. Among these criticisms is that mental health courts may inappropriately privilege criminal behavior by the provision of expedited comprehensive services to persons with mental illness who commit criminal offenses and, in doing so, reduce or delay the provision of services to persons with mental illness who do not engage in criminal behavior. This article explores the mechanisms that may result in “queue-jumping” and analyzes whether a priority to offenders, when it does occur, is justifiable.

*Key Words: mental health courts, queue-jumping, resource allocation, mental health services, mental health ethics.*

### Queue-Jumping: Do Mental Health Courts Privilege Criminal Behavior?

*“The squeaky wheel gets the grease.”*

Traditional folk saying

### Introduction

Rooted in the notion of therapeutic justice, mental health courts (MHCs) were created with the goal of diverting persons with mental illness who commit criminal offenses to much needed mental health services rather than incarceration (Schneider, 2007; Stefan and Winick, 2005). Born partly out of recognition that an inordinate percentage of the prison population had some form of mental illness, this effort to “decriminalize” mental illness also sought to find a more appropriate and constructive way to deal with persons with mental illness who

commit minor offenses (Griffin et al., 2002). However laudable the intention, the criticism arose that MHCs may inadvertently function as a short cut to access scarce treatment resources (Wolff, 2002; Seltzer, 2005, Hoskins, 2007). It has further been asserted that the expedited route to mental health services via MHCs may also result in an incentive to criminal behavior (Wolff, 2002; Schneider et al., 2007). This paper explores the notion of “queue-jumping” in the context of MHCs and examines conceptually whether MHCs “reward” criminal behavior by a “priority” provision of mental health services to persons who violate the law (offenders) over those who do not (non-offenders) (see e.g., Schneider et al., 2007; Steadman et al., 2001).

By viewing MHCs in the broader context of availability of services for people with mental illness, generally, this article aims to add to the discussion a dedicated conceptual examination of the criticism that the provision of expedited comprehensive mental health services via MHCs constitutes an unfair allocation of resources. Given the diversity in practices and procedures of MHCs across Canada and the U.S., this article addresses mechanisms that may be a factor in the existence or absence of the phenomenon of queue-jumping or unfair allocation of resources rather than on specific MHCs. Moreover, given the paucity of empirical data being collected and maintained on MHCs (Schneider, 2007; Sinaiko and McGuire, 2006; Redlich, et al., 2006), and the limitations on generalizability from data derived from a single court or court system, this conceptual analysis does not attempt to examine the question empirically, but rather ultimately seeks to contribute to a discussion about the fairness of mental health resource allocation.

### Background

Mental health courts, premised on the notion of therapeutic justice, have become an increasingly appealing way of dealing with what is widely, although not uniformly, seen as the inappropriate incarceration of people who engage in criminal behavior caused by mental illness. As a result, the number of mental health courts in North America has increased substantially in the past decade (Redlich et al., 2006). Canada’s newest MHC will be instituted in Nova Scotia (General Assembly, Nova Scotia, Bill No. 21, section 4(1); 2007) in 2009, following Ontario and New Brunswick (and pilot programs in Newfoundland and Labrador). Although there are several different models for MHCs, some features are considered essential. Most MHCs courts still limit the availability of therapeutic diversion to minor or moderately serious offenses, with a few exceptions that offer diversion to felony offenders

who meet specific criteria (see e.g., Griffin et al., 2002; Stefan and Winick, 2005). Additionally, all MHCs typically involve prompt assessment of mental health status and a finding that the mental illness was the cause of the offense. If appropriate, the option to engage in therapeutic diversion rather than the traditional criminal justice is extended to eligible defendants. MHCs then impose a requirement that the offender undergo treatment for the mental illness, accompanied by monitoring of treatment compliance and graduated sanctions for non-compliance (Thompson et al., 2007; Hoskins, 2007). In this way, MHCs offer an alternative to offenders with mental illness by affording them the opportunity to treat the underlying illness, arguably benefiting both the offender and society by reducing recidivism and avoiding inappropriate (and potentially harmful) detention (see Schizophrenia Society of Canada (SSC), 2005).

Nevertheless, mental health courts are not without their critics. A number of objections have been raised against the implementation of MHCs. Among these criticisms are 1) that there should not be a “separate justice” system for the mentally ill as it creates stigma and is inconsistent with fundamental principles of equal justice (Stefan and Winick, 2005; Wolff, 2002) 2) that it is questionable whether mentally ill offenders understand and appreciate the consequences of choosing diversion (e.g. some courts require a guilty plea) (Redlich, 2005; Stafford and Wygant, 2005) 3) that the “coerciveness” of mandatory treatment is unfair (Stefan and Winick, 2005) and 4) that MHCs may give priority to offenders over non-offenders (Sinaiko and McGuire, 2006; Wolff, 2002; see also Schneider, 2007, 64), such that rather than expanding the pie of services for mentally ill persons, MHCs preferentially divert scarce resources to persons who have committed criminal acts.

## Analysis

As noted, a common feature of MHCs is the presence of an expedited process to assess and treat mental health involving a coordinated treatment team that provides ongoing assessment of treatment and monitoring of compliance. It has been observed that this expedited comprehensive treatment for offenders may disadvantage non-offenders who may remain completely outside the health care system, or experience delay in receiving any treatment. Thus, the question must be asked whether this system of expedited services and attention to the subpopulation of mentally ill persons who engage in criminal behavior is fair with respect to the non-offender population.

## Do MHCs Lead to Queue Jumping?

This analysis begins with a recognition of the complexities involved in getting mental health services to persons with mental illness, not all of whom are readily identifiable, may present with fluctuating symptoms, or may not be interested in receiving services or treatment. Furthermore, the situation is made more difficult by the fact of limited resources for the provision of services, which is intensified in the current cost-cutting climate. Thus, it is imperative to note at the outset that any conclusion that can be drawn from this analysis is one that takes as its starting point an imperfect system with finite resources, resulting in an inevitable, but not necessarily unfair, shortage of services to some people who need them.

## Is it Really Queue Jumping?

Queue-jumping or “line bumping” (Schneider et al., 2007) can be said to refer to a disruption in the order of a system in which resources are allocated based on sequential presentation of those who would receive those goods. And in order for there to be queue-jumping in the case of MHCs, it must first be established that there is a queue of some sort. (Queues can take many forms, e.g., scheduling of non-emergency hospital appointments or buying tickets to a movie.) It is important to note that this need not be a single file as very often demands on scarce resources come from multiple sources and entry points. Nevertheless, where there is some ordering of allocation of finite scarce resources, (as there must necessarily be), some will receive services and others will not. Any disruption in the ordering must be justified. In the case of MHCs, there generally is a system that orders the receipt of services among those who need them. However, depending on the practices and procedures of the MHCs, the order of that queue may not necessarily be affected by the provision of services to offenders.

Consider a scenario in which several people with mental illness have sought treatment but must wait their turn. Consider then that the commission of a criminal offense by one of them removes that person from the line. Following this, there are several occurrences that may affect the allocation of resources. First, there must be an assessment of the accused that determines that there is mental illness and that this mental illness caused the person to commit the offense (see e.g., General Assembly, Nova Scotia, Bill No. 21, section 4(1); 2007; Schneider et al., 2007). Treatment for the illness can begin in detention during this process. Next, if eligible, the accused may choose to proceed through the traditional criminal justice system or through a MHC, where a required treatment program will be outlined backed by graduated sanctions for non-compliance. The impact on the “queue” of this diversion and whether this diversion constitutes queue-jumping depends upon several factors, e.g. 1) whether there was a waiting list for those mental health services, as there often is 2) if the offender was in queue for services, i.e. waitlisted, where in the order he was (i.e., if at the front of the line, the offender may actually receive services later than he would have had he not committed the criminal act) and 3) what the ultimate disposition of the case turns out to be (e.g. non-compliance, in which case fewer community services are consumed, or incarceration in which case services are likely to be consumed from a different pool). If the offender has not sought mental health services, then the effect on queue-jumping or “line-bumping” (Schneider, 2007) of diversion through a MHC would be different in view of the fact that someone who was not waiting for services suddenly becomes among the first to receive them. The Schizophrenia Society of Canada has identified the need to gain assurances that the system can accept a new client before a judge makes a determination regarding referral to community based services as a characteristic typifying well-functioning MHCs (SSC, 2005). Given the concern about a reduction in community mental health services available to non-offenders vis-a-vis offenders, careful scrutiny of procedures that may operate to the detriment of non-offenders is warranted.

Consequently, it is not clear that diversion of a mentally ill offender to a MHC always necessarily results in queue-jumping. Nevertheless, the system is such that in some instances, an offender may gain

access to services in a manner that disadvantages a non-offender. For example, where there are waiting lists for community mental health services and the MHC does not or cannot require that the offender assume her place on the waiting list, this could clearly result in “queue-jumping” as the diverted or detained offender must consume mental health resources from some source in order to undergo the required treatment, and thus consumes resources ahead of non-offenders. However, to the extent that MHCs require that there be space available before allowing diversion or that the offender join an existing waiting list, the problem of queue-jumping with regard to community mental health resources may be minimized somewhat. This, of course, would result in extended detention for the offender (and additional consumption of forensic resources). Nevertheless, priority allocation to offenders may occur. Thus, in most instances the more appropriate question is whether this priority allocation can be justified.

Here, I briefly explore three arguments regarding whether priority allocation of mental health resources is unfair when viewed independently and within the broader context of availability of services to non-offenders. These arguments—1) whether the priority allocation helps the “worst off” 2) the acceptability of the counterfactual and 3) satisfying the goals of (therapeutic) justice, together suggest that some privilege favoring offenders may not be unfair.

### Helping the Worst Off

MHCs offer an option that is tailored to the unique needs of the population that comes before it. Essentially, the criticism of unfair allocation of resources claims that of two identifiable populations—1) persons with mental illness who do not engage in criminal acts (non-offenders) and 2) persons with mental illness who do engage in criminal acts (offenders), that MHCs unfairly divert services to offenders. However, the values underlying this diversion could yield an explanation that renders a priority allocation to offenders both fair and desirable.

A theory that is sometimes applied to problems of resource allocation suggests that goods should be distributed equally, but where there is necessarily an unequal distribution of goods, that any inequality should benefit the least advantaged. (Although this simplified description of Rawls’ “Difference Principle” was initially intended to direct benefit the least well off *economically*, this principle may still be useful in considering the dilemma at hand.) (Rawls, 2003) Indeed, the distribution of mental health services via MHCs may in some instances give priority access to offenders over non-offenders; however, in applying a loose construction of the *difference principle*, it may be that this priority distribution, when it does occur, benefits the “worst off”. Thus, this analysis does not hinge on a single conception of “worst off” rather “worst off” may refer to characterization of predicament, health status, and economic or future prospects.

Michael Seto and colleagues conducted a study which, in 2004, constituted the largest empirical comparison of forensic and non-forensic psychiatric patients (Seto et al., 2004) This study measured these two patient populations on criminogenic, clinical, and social problems. Seto and colleagues found that forensic patients typically scored lower on all three variables, leading the researchers to conclude that forensic patients are actually less impaired than

civil patients and this may be due to longer hospital detention of forensic patients leading to better outcomes (Seto et al., 2004) These findings are significant to many aspects of this analysis, as will be further discussed in the following section.

However, regarding whether the forensic population (of which those diverted through MHCs are a subset), how “worst off” is defined, figures prominently in analysis of this issue. Even if client profiles are similar as between offenders and non-offenders as the Seto study suggests, the fact of entry into the criminal justice system changes some aspects of their characterization. As between these two populations, an argument could be made that offenders are, in fact, more disadvantaged than non-offenders because, while both groups suffer from illness, one group also has the added disadvantage of a criminal prosecution, (the possibility of) a criminal record, and the loss of certain freedoms. Moreover, if MHC assessments of eligibility are accurate, one could also make the claim that the mental illness may be more troublesome because it was such that it caused the individual to engage in criminal behavior. Given that this “causation” element is a required finding for eligibility for MHCs, there may be some basis for this claim. Therefore, to the extent that there is a priority allocation of services to offenders, it may be justified because it arguably benefits the least well off, depending on how that characterization is made.

### Considering the Counterfactual: Allocation of MHS Without MHCs

In the absence of MHCs mental health services are available to offenders through the criminal justice/prison system and various interim and long term detention arrangements (Schneider, 2007). Since health care (including mental health care) is mandatory for inmates, offenders will still have access to services even without the existence of MHCs, but from a different pool. However, the nature, quality, and consistency of services provided to incarcerated individuals varies considerably. Furthermore, the delivery of mental health services in an unsafe environment (like many jails or prison) is likely to undermine any benefit gained from treatment. Thus, neither the individual offender nor society gains by the incarceration of non-dangerous persons with mental illness. Moreover, given that the comprehensive treatment of offenders may reduce recidivism and facilitate the offender’s ability to become a contributing member of society, MHCs may ultimately serve to expand the pool of resources available to non-offenders. (See also Calgary Diversion Project, Final Evaluation Report, as cited by SSC, 2005 showing a decrease in the number of police complaints and “a significant reduction of costs to the health system” due to less utilization of emergency rooms and reduction of inpatient hospital days (SSC, 2005).

Furthermore, Seto and colleagues point out that because forensic patients are less impaired than civil patients typically, that many forensic patients “could be appropriately diverted into general mental health services”, thus freeing up demand on forensic resources (Seto et al., 2004). This is, in fact, what MHCs do in identifying a subset of the forensic population for re-entry into the community and uptake of community resources.

### Goals of (Therapeutic) Justice

Some critics of MHCs have called these courts “misguided” (see

e.g., Seltzer, 2005). They insist that there should not be separate justice for specific populations, and that everyone should be subject to the same laws, with any special considerations to come at the point of sentencing (see e.g. Wolff, 2002). This analysis takes the position that therapeutic justice is not, in fact, separate justice. Rather therapeutic justice is considered here to be one of many avenues that can be used to achieve justice. Nevertheless, therapeutic justice should not “trump” other legal principles (Casey, 2000).

The goal of therapeutic justice as one of bridging rights and care perspectives (Casey, 2000), has resulted in “specialty courts”, e.g., drug and mental health courts (see e.g., Winick and Wexler, 2002). These represent institutional recognition of the different considerations necessary to administer justice with particular populations or types of offenses. However, these institutions should also be viewed contextually. Creating a luxury facility for young people who use cocaine, while doing nothing about substandard services for persons who use other illegal substances, could seem irresponsible. Even if admirable when viewed on its own merits, viewed contextually, this initiative may seem misguided and possibly creates incentives to undesirable behavior. MHCs do not present so clear a picture, but concerns about preferential treatment of offenders has been raised. While MHCs may be a positive move toward justice when viewed narrowly, they must also meet the requirements of contextual fairness.

Thus, whether therapeutic justice is at odds with fair allocation of mental health services seems to depend largely on the procedures of the MHC regarding access to community treatment services. On the one hand, it would appear that diversion of mentally ill offenders avoids treating them in ways that serve neither them nor society would constitute a benefit. Yet, on the other hand, consuming resources at the expense of non-offenders would seem to contradict another sense of fairness. Furthermore, processing offenders through the traditional criminal justice system arguably does not satisfy its objectives given that the goals of incarceration are generally punishment, deterrence, and public safety (however also see General Assembly, Nova Scotia, Bill No. 21, section 4(2)(c) acknowledging the goal of MHC to protect the rights of the public, the accused and the integrity of the criminal justice system, 2007). For a person who has committed a crime because of mental illness, neither punishment nor deterrence is achieved. Moreover, since MHCs typically limit participants to misdemeanants, public safety is generally not a major issue. Instead, continued involvement in the community, along with appropriate treatment and supports are more likely to serve the goals of therapeutic justice and be consistent with traditional justice, particularly given graduated sanctions involving community service by offenders (see Griffin et al., 2002 noting an aversion to community service).

### **Inadvertent Incentive and the “Squeaky Wheel”**

A remaining question is whether MHCs provide inappropriate incentives to criminal behavior (see e.g., Wolff, 2002, SSC, 2005) because they promptly provide services to persons who come to the “negative” attention of the authorities. The fact is that if a group of individuals are gathered in a park, it will be the one who urinates on private property or harasses a passerby because of a disordered mental state who will be taken away and given treatment, support, and ongoing assessment (see Schneider et al., 2007, 17). However,

because of the eligibility criteria for most MHCs, i.e. that mental illness caused the person to commit the offense; it seems highly improbable that priority treatment operates as an incentive to criminal behavior for one who commits a crime because of mental illness. The requisite level of deliberation is inconsistent with the MHC eligibility criteria.

Opponents of MHCs may point to the careful attention and treatment that is given to offenders who are diverted through MHCs. While it would be desirable to provide this level of comprehensive treatment to all persons needing mental health services, the reason that this level of service can be provided to offenders is because they are now within the jurisdiction of the courts. This jurisdictional authority gives the coordinated diversion team the leverage to get treatment to persons who need it but may not seek it or will not voluntarily adhere to a treatment program otherwise. So while offenders are provided with a comprehensive treatment program, it is within a coercive framework by virtue of the leverage of the threat of jail, a criminal record, and/or community service.

### **Coercive Nature of MHCs as the Mechanism of Unequal Allocation**

If comprehensive mental health services (often including housing and occupational training) taken up by offenders with mental illness is due to the fact that MHCs have the leverage to compel receipt of these services, then this should be noted. Nevertheless, there is disagreement about the impact of this leverage (see Redlich et al., 2006 finding no association between leverage and compliance; but also see Poythross et al., 2002 for discussion of findings of impact on compliance).

However, if the actual priority benefit to offenders is the compulsory comprehensive treatment program, then perhaps the antidote is to make similarly coercive treatment programs available to non-offenders. Different forms of this exist in programs with community treatment orders (CTOs) and preventive outpatient commitment (see Schneider et al., 2007; Stefan and Winick, 2005). While these programs may present in many different forms, they typically seek agreement from the prospective patient (see Schneider et al., 2007 for discussion of Toronto program) However, such programs have met with questions about effectiveness (Winick, 2003), not to mention controversy (see Stefan and Winick, 2005). However, if it is compulsory comprehensive treatment that is the unequally distributed “good”, then the charge would be to identify a satisfactory mechanism that makes this “good” equally available to non-offenders. Such a mechanism could involve allowing non-offenders to enter into “Ulysses contracts” whereby they voluntarily bind themselves to a course of treatment backed by sanctions that might include, for example, community service (see Griffin et al., 2002 for anecdotal reference to aversion to community service). Of course, the true leverage of these agreed-to sanctions may be questionable.

### **Conclusion**

The impact of MHCs on the provision of services to persons with mental illness is complex and seems to depend on several factors, foremost of which are MHC practices and procedures in ensuring that community services are, in fact available, before referring offenders and careful assessment of eligibility for MHC diversion in

the finding that the mental illness caused the criminal behavior. Nevertheless, diversions by MHC may still result in queue-jumping or other priority allocation of resources to offenders. This analysis concludes that even if MHCs result in some advantage to offenders in the distribution of resources, this inequality may be justifiable on the grounds that 1) this distribution works to the benefit of the “worst off” 2) it best achieves the goals of therapeutic justice and 3) is consistent with principles of traditional and therapeutic justice. As many have observed, further empirical work and evaluations of the effectiveness of MHCs is needed. This analysis does highlight the implications of a possible variation in the uptake of comprehensive treatment programs that may result in better outcomes for MHC clients. Whether this uptake, albeit driven by compulsion, serves as an incentive to criminal behavior seems unlikely given that eligibility criteria for MHCs would seem to negate this possibility. But this, too, is subject to empirical challenge. Furthermore, because these services are generally available to non-offenders through community treatment programs, it seems difficult to substantiate a claim that MHCs inherently privilege criminal behavior. Indeed, it may only be the “compulsion” or leverage that is generally not available to non-offenders. If it is not access, but rather “compulsion” that leads to better outcomes then, absent a wide embrace of compulsory psychiatric intervention for non-dangerous non-offenders, this dilemma may persist unless a program is devised that allows non-offenders to voluntarily enter into a form of “Ulysses contracts” whereby they can bind themselves to future sanctions for non-compliance with treatment programs. Yet, issues of competency and liberty make this a complex option.

That a mentally ill offender takes a space in community treatment is not necessarily unfair to non-offenders. It is important to remember that the offender is a member of the population for whom the services were designed and that to process this individual through the traditional court system does not serve the ends of justice nor improve the condition of the person with mental illness. In the end, MHCs can benefit criminally accused persons with mental illness, the community by way of reduced recidivism and, arguably, the non-offender population as well, if the lack of recidivism and productivity of the “well offender” results in more resources available for the general pool. Nevertheless, questions of unfair allocation of resources and inappropriate incentive are important ones that warrant ongoing close scrutiny.

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## Therapy and Feeling Secure

Submitted by: Cheryl Yarek

Case Manager

Cheryl Yarek is a Case Manager with a specialty in peer support. She works on the South Etobicoke ACT Team (Toronto, Canada) and has been writing about recovery since her initial diagnosis in 1984.

I spent many years in therapy, and when I felt a lot more secure, I labelled my therapy a huge success. It was some time after that, in seeing a work counsellor, that I was able to identify and name nine core securities.

Ellis began the process by asking me, “What constitutes security for you?”

### 1) Knowing How To Handle Difficult Situations Well:

This skill-building took place over a period of decades in my life. One day, I woke up pretty smart. Many situations are resolved through “doing or action,” and this involves respecting both the other person and yourself. It is normal for me to resolve issues at work involving colleagues without the help of management. In one instance, I resolved months of conflict with a fellow team member by finding the right time to have a frank and honest dialogue. That means no “attacking” and no “blaming” either.

Our discussion was private and largely positive. I let my colleague know that I believed our difficulties were caused by *our strengths* being very similar. After our talk, I followed up with the purchase of 10 packages of sugarless gum tied together with colourful ribbons. (Gum chewing was a liking we shared.) Soon after, this former adversary became one of my greatest supports at work.

### 2) Being Able to Laugh Later, Especially at Myself, When Events in Life Have Been Almost Too Challenging:

In the midst of a crisis, confusion reigns. Sometimes, I am not even certain *what* I think. When asked, I can be blank and silent. It is only with resolution of the crisis that perspective is gained. I have always felt that therapy is very much about perspective; achieving a healthy one. With perspective comes the ability to manage your emotions, your thoughts, and your situation. How does laughter fit into this equation? Whenever I can look back and laugh with heart at a situation, I know my healing about the matter is complete.

### 3) Knowing Myself, Especially My Vulnerabilities:

In order to get to know yourself, you’ll combine your own insights with the views of others around you. I was a romantic and always believed that it is better to have loved and lost than never to have loved. Sometimes, though, I suffered tremendously. This left me wondering if my energy in this area was a personality trait or something less complimentary, like madness. How big a risk should you take in love? I recognize that I have taken substantial risks in many areas of my life so my losses have been enormous and my gains have been huge too. Talking about one situation of the heart recently, a friend said, “Remember, I will be there for you whichever way it goes.” I found this remark touching and realized my exterior is very strong and resilient, however, as a client of mine observed, “Inside you, Cheryl, you are a marshmallow.”

### 4) Being Creative, Dreaming BIG:

In practical terms, I need to worry if factors impact negatively on my confidence. It is impossible to dream BIG and think negative. This does not mean I should determine every detail of every word or action I take, I also need to leave room for intuition and impulse. I keep a “Compliments Journal” to help me focus on the positives about myself but all parts have merit. Remember, the Japanese believe the “unpainted” part of the canvas is no less important than the painted parts. It also needs to be chosen.

“Emotion” is rarely celebrated, especially in mental health. However, emotion is very important to ME. My view is that great things are usually created by the celebration of emotion rather than the presentation of logic.

### 5) Accepting Others as I Find Them, While Pushing Myself to Reach Excellence:

My experience is that people feel most heard when they know they are not being judged. When it comes to friendship, it can be a tight-rope walk to balance friendship and judgement. I love my friends, which causes me to want to protect them. However, I also recognize that I grew most after falling down several times. Unless a friend’s personal safety is in danger, I don’t *usually* intervene.

In my life, I have chosen a few things I am very interested in and have pursued these interests until I am very versed in them, e.g., writing, mental health and fitness. Recently, I have expanded to include abstract art and mixed media as areas to focus on. I have used materials new for me such as molding clay, acrylic paint,

photography, collage, dried flowers, and broken mirror and glass. Time spent on my art is a genuine break from my career in mental health. I feel it is the kind of distraction and the kind of rest that my thoughts and feelings need.

## **6) Learning from The Past; Protection From Further Trauma:**

Something I do not want to put any more therapy energy into is exploring details of my past. The fact that those in my immediate family do not see things as I do can be crazymaking for me. I now realize that it is very possible for one person to be viewed several ways and for that person to have a different relationship with a number of different people. My mother always told us that, "There is nothing so bad that significant good does not come of it." This summarizes my journey to this point. Often, the worst things I encountered turned out later to be some of the best things that happened to me. As they say, "What doesn't kill you, makes you stronger." Some of us, though, have dealt with the resulting trauma and the horrors of barely surviving. I now have a built-in radar for abusive relationships and situations. My psychiatrist agrees this comes in handy and she also knows the price exacted for these skills.

## **7) Looking At the Breadth of my Life and Feeling Something Greater Than Happiness... Feeling Contentment:**

Despite the horrors and some resulting mistakes, I am proud of my journey and what I have done with my life. I have taken negatives and made positives. Because I learned to forgive myself for my mistakes, I am gracious about other people's errors. So much of my life was a struggle. I don't feel that way now. Now, there are only difficulties. Do I imagine I will completely fail or not have the resources to cope? No.

My day-to-day life contains many happy moments and I have learned that there is something even greater than happiness. There is contentment. Contentment for me means my responsibilities are demanding but they are also interesting, challenging, my boredom level is zero, and I have the supports to be able to meet those demands. To spend each day knowing you are making a difference in the lives of others and watching those individuals evolve and grow, is amazing; to have the caring and love returned, is phenomenal.

## **8) Knowing With a Little Help, I Can Work Out Anything Life Throws Me:**

The day I discovered that counselling was available to me for almost any issue I might name, I was thrilled. When I was in my 20s and had serious problems. I was too embarrassed to seek help. I believed that you had to be weak or even worse, "strange" to turn to a counsellor. At fifty-one, I swear I would see two or three counsellors at once if I could. I am certain my love of counselling has a lot to do with the excellent counsellors I have had like my psychiatrist and my work counsellors. I think it is important to understand that aside from resolving issues, additional support can mean better habits (journaling rather than having a drink), and takes the stress off friends and family so those interactions are more relaxed and fun.

## **9) Being Grateful:**

I mention this last intentionally. I hope it is something you take away. If you were asked what you are grateful for, would your list be long or short? Once I began my list, I realized I couldn't possibly finish it. There is very little I am NOT grateful for. I believe it is important to remember, as the Chinese do, that crisis equals opportunity.

Some of my worst moments and situations have been instrumental in formulating the reach and depth of my understanding and empathy for others. And that means everything to me.

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## Mental Illness and the Medical Student: The Disturbing Reality of Medical Student Perspectives

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"I am a medical student at McMaster University (Hamilton, Canada) in my final year of study. Next year I hope to pursue a residency in rural family medicine with a special focus on mental health issues and women's health."

Empathy. Compassion. Patience. These are words that frequent medical schools' admissions information websites for qualities their most desirable candidates possess. On average, over 10,000<sup>1</sup> people apply to medical school each year in Canada with successful admission of 25 per cent of these candidates. This translates to 2,500 qualified men and women, handpicked with the above characteristics in mind. These statistics then beg the question; when it comes to mental illness, why are medical students and physicians among the most unsympathetic, impatient and frustrated groups that deliver health care to this patient population?

In a recent study published by the *Journal of Medical Education*<sup>2</sup>, Dixon and his colleagues found that when medical students were presented with case vignettes and asked to rate their attitudes toward a particular patient, students reacted much less favorably to patients with a diagnosed mental illness than patients deemed in good health or suffering from chronic illness. Among the possible explanations for this shift in attitude included the beliefs students held that patients suffering from mental illness were less compliant, required more of their time and tended to be more prone to substance abuse. These beliefs, combined with mainstream society's often stigmatized portrayal of mental health issues, highlights a real and important issue in current medical education. Physicians-to-be are cultivating and preserving an attitude of frustration and annoyance when dealing with mental health patients rather than one of compassion and empathy—one we are quick to offer to patients affected by more somatically presenting disease.

The need for aggressive shifts in the training delivered to medical students in the area of mental health is not only for the good of

their future patients; medical students and physicians are among the highest rated groups in society likely to suffer from mental illness during their lifetime<sup>3</sup>. Drug abuse, anxiety, depression and suicidality are only some of the disorders that have been linked as outcomes in response to the stresses associated with the training, professional responsibilities and personal sacrifices needed to practice medicine. Statistics<sup>3</sup> suggest as many as 15 per cent of physicians will be impaired by psychiatric illness at some point in their lives. As a group, physicians and medical students tend to be viewed as exceptionally assiduous and high achieving individuals. Ironically, these are the same traits that predispose an individual to deny personal issues and neglect self-care in exchange for longer work hours and career advancement.

Medical students, in particular, have reported<sup>4</sup> numerous barriers to seeking help for mental illness. Among them the fear they may jeopardize their future careers, that it would be difficult to keep their treatment confidential and that they would be stigmatized by the medical community for seeking help. It has been my experience that while many students are celebrated for displaying the strength it takes to seek help, there is still the notion that colleagues will view those affected by mental illness in the workplace as "weak" and emotionally friable. It is little wonder that the preconceived notions held by medical students regarding patients with diagnosed psychiatric conditions would translate to their notions regarding colleagues who develop similar psychiatric problems.

Change is needed now. Not only for the well-being and better care of our patients but also for the recognition that we as physicians and physicians-to-be are among the most at risk of membership to a group that we are implicitly taught to stigmatize early on in our training. Medical education needs to have a stronger focus on early exposure to psychiatric illness. Furthermore, medical schools need to incorporate into their curriculum ways to foster the traits in the domain of mental health that garnered their students' admission to their programs – empathy, patience and compassion. I will continue to expect this from myself, my colleagues and my own physician, especially in the area of mental health. I hope you will as well.

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# BOOK REVIEW

## ***Geriatric Mental Health Ethics: A Casebook***

**Author:** Shane S. Bush, PhD

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**D**r. Bush is a practicing neuropsychologist<sup>1</sup> and his other books, some of which were written with other people, examine ethics in the context of psychology, neuropsychology, clinical neuropsychology, and forensic psychology. In this newest book, the focus is ethical aspects of mental health professionals' treatment and care of older people. Relatively few books have been published specifically about this area of healthcare so new discussions are welcome.

The author sets four goals for *GMHE*; they are to: (1) describe ethical challenges routinely encountered by professionals who treat elderly people; (2) identify available resources; (3) explain his own model for ethical decision making; and (4) apply this model to different clinical situations. As highlighted in the book's title, clinical scenarios are employed extensively. Chapters 5 to 13 tackle different cases and in total, twelve cases are in the book.

Bush's decision making model is utilized in cases about professional competence, personal relationships, privacy and informed consent, psychological assessment, treatment, seniors who belong to special populations (e.g., ethnic, religious), and health promotion. The cases' settings vary too: hospitals, skilled nursing facilities, independent practices and outpatient clinics. And, finally, the perspectives range from that of a neuropsychologist to a psychiatrist, a counselor and a social worker.

The book has three strengths. First, the cases are not the overly simplified kind used much too frequently, but instead include realistically complicating details. Moreover, the inclusion of different professional perspectives and treatment settings avoids a common tendency to focus just on MDs and PhDs. Second, the target audience is practicing mental health workers who typically seek out information that effectively and efficiently contributes to the quality of their work with clients and their families. The clear writing style and text formatting therefore should be much appreciated. Third, repeated application of the ten-step model,

which is quite comprehensive, will increase readers' understanding of what, at first blush, seems rather daunting.

The concluding section of the book includes a quote from Beauchamp and Childress: "often what applies most in the moral life is not consistent adherence to principles and rules, but reliable character, good moral sense, and emotional responsiveness" (144). While these factors appear in various cases, they are not obvious enough in comparison to the various principles and rules employed. Admittedly in the opening pages of *GMHE*, Bush adds a caveat that this book is based on his earlier publications, which have more conceptual explorations. And it is understandably frustrating to practitioners if theoretically dense concepts (e.g., authenticity, embodiment, agency) are poorly explained and never connected to actual interactions between clients and their mental health workers. Nonetheless, more explicit attention to people's character and integrity, situational meanings and working with people's emotional life is warranted.

Another shortcoming is the absence of common problems in mental healthcare such as psychotic disorders, manic disorders, personality disorders, addictions, diagnostic uncertainty, patients who are treatment refractory, trauma and violence, suicidality and self-harm, involuntary hospitalization and treatment, and use of restraints and seclusion. Mental healthcare must deal with serious social justice challenges that are absent in much of acute care, physical medicine. These challenges include the all-too-real impact of social determinants of health (e.g., poverty, homelessness, immigration), marginalization, stigma, and the involvement of the criminal justice system. Unfortunately such challenges are not addressed enough by the cases.

In closing, the book's primary content is presented in just 140 or so pages and so it will appeal to busy mental health workers to read. Bush's model can help professionals tackle ethical considerations as thoroughly, conscientiously and strategically as they tackle clini-

cal considerations, and this is a good thing. However, for mental health treatment and care of older people, the book and model's helpfulness for more complex, yet still common, mental health concerns and dilemmas still needs to be demonstrated. This is something I look forward to.

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**Footnotes:**

1. Neuropsychology is a subspecialty of psychology. It involves the study of brain structure and functioning as they relate to our psychological processes and behaviour

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**Competing Interests:** *I am a contributing editor for JEMH. I am employed by CAMH, which helped launch JEMH and has supported its past annual conferences. Two senior manager/executives of CAMH are on the Journal's editorial board (Ms. Gail Czukar and Mr. John Trainor).*

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