Families for
Addiction Recovery

Addressing stigma through clinical judgment: Strategies for working with families

META:PHI Conference 2021

Sept. 25, 2021

Acknowledgements

Presenters:

Oona St-Amant, RN, PhD, Associate Professor, Ryerson University

Brynlea Barbeau, MD, Addiction Medicine Physician, RAAM, Head of Services for Addiction Medicine, Sault Area Hospital

Angie Hamilton, LLB, Executive Director, Families for Addiction Recovery

Co-Authors:

Monica Hughes, RPN, Scarborough Health Network Centenary Hospital

Barbara Watts, MD, CCFP, Emergency Physician Grey Bruce Health Services, Hospitalist Physician Headwaters Healthcare Centre

Louise White, RN, Co-Founder, Families for Addiction Recovery

META:PHI Conference 2021

Disclosure of Financial Support

No External Support

Families for
Addiction Recovery

META:PHI Conference 2021

Learning Objectives

- To reflect on three clinical vignettes related to the application of health laws regarding consent and capacity, harm to self/others and privacy in clinical practice.
- To engage the audience in meaningful discussion related to the application of these health laws as they relate to family involvement.
- To extend knowledge related to effective family-centred therapeutic approaches in clinical practice.

Background

- Evidence supports family-centred approaches in preventing and managing SUD[1,2]
- Family caregivers involvement is an important and effective strategy for initiating treatment, reducing rates of hospitalization and poisoning [3,4]
- Family caregivers experience both *vicarious* and *public* stigma when they are associated with perceived moral failures of their relatives[5]

Overview of Ontario Health Laws

Health Care Consent Act (HCCA)

Two-part test for capacity to make treatment decisions:

1. Be able to **understand** the information that is relevant to making the decision about the treatment; and

2. Be able to **appreciate** the reasonable foreseeable consequences of a decision or lack of a decision

Overview of Ontario Health Laws

Mental Health Act (MHA)

- Criteria for **assessments and admissions** (not treatment):

- suffering from a **mental disorder;** and
- it's likely to result in:
  - serious bodily **harm** to self;
  - serious bodily harm to others; or
  - serious physical impairment of the person unless remains in custody of a psychiatric facility

Overview of Ontario Health Laws

Personal Health Information Protection Act (PHIPA)

- provides rules for the collection, use and disclosure of personal health information about patients that protect privacy and facilitate the effective provision of health care

- if a patient is not capable of making a treatment decision, then the substitute decision maker (SDM) is entitled to receive the relevant information and to make decisions

Clinical Vignette #1 : SHAHIR

Medical History: SUD, homeless, previous overdose in Feb. 2021 (fentanyl), naloxone administered, depression, anxiety disorder, no fixed address

09-10-2021- 0314 – ER - EMS Report – Shahir, a 17-year-old male was found unresponsive in a stairwell. A stranger called 911. Upon arrival, patient had slow, agonal respirations (RR 5), bradycardia with irregular pulse rhythm (HR 39), hypotension (BP 90/45), hypoxia (SpO2 84% on RA), and mild hypothermia (temp 35). Skin clammy and cool to touch with generalized pallor, capillary refill > 2 sec. Pupils myotic (< 2 mm). Paramedics administered Naloxone 0.4mg x2, with effect. Patient was started on O2 via nasal prong, IV access was obtained and brought to hospital.

09-10-2021 - 0346 – ER - Patient stabilized in the ED, arrived unaccompanied. Despite being oriented x3 after stabilization, patient has periods of restlessness and agitation. Patient has visible open fracture of Lt radial and ulnar bone. Patient refuses contact with family.

09-10-2021 – 0520 – Patient has sx for open fracture.

10-10-2021 – 0626 – PACU – Patient is febrile (temp 39.6), tachycardia (HR 122), dyspnea (RR 10), SpO2 95%. Blood cultures from the day before growing gram positive cocci. Patient started on IV antibiotics for presumed endocarditis. Echo pending.

10-10-2021 – 0755 – Post-Operative Unit – Patient refuses care and is preparing to leave AMA.

Families for
Addiction Recovery

Poll 1

Do you think this patient has capacity to make treatment decisions related to their endocarditis?

Do you think this patient has capacity to make treatment decisions related to their SUD?

Would you involve family ?

Do you consider this patient a risk for harm to self?

Clinical Vignette #2: FAYE

Medical history: Depression, anxiety disorder, anorexia nervosa

09-10-2021 - 0314 – EMS Report – Faye, a 16-year-old female was found unresponsive in a stairwell. Parents called 911. Upon arrival, patient had irregular respirations (RR 35), SOB, pulmonary crepitations at bases of lungs. bradycardia with irregular rhythm (HR 39), hypotension (BP 70/30), and mild hypothermia (temp 35). Appears cachectic. Patient was started on O2 via nasal prong, IV access was obtained and brought to hospital.

09-10-2021 - 0346 – ER - Patient stabilized in the ED, arrived unaccompanied. Despite being oriented x3 after stabilization, patient has periods of restlessness and agitation. Patient has visible open fracture of Lt radial and ulnar bones. Patient refuses contact with family.

09-10-2021 – 0426 – CXR – shows pulmonary venous redistribution. ECG ordered. Suspected CHF.

09-10-2021 – 0520 – Patient has sx for open fracture.

10-10-2021 – 0755 – Post-Operative Unit – Patient refuses care and is preparing to leave AMA.

Families for
Addiction Recovery

Poll 2

Do you think this patient has capacity to make treatment decisions related to their CHF?

Do you think this patient has capacity to make treatment decisions related to their eating disorder?

Would you involve family?

Do you consider this patient a risk for harm to self?

Clinical Vignette #3: EDWARD

Medical History: dementia (MMSE 20) May 2021, COPD, DM2, hip replacement (2014)

09-10-2021 - 0314 - EMS Report –Edward, an 84-year-old male was found unresponsive in a stairwell. A staff member at his retirement home called 911. Upon arrival, patient tachypneic (RR 35), tachycardia with irregular rhythm (HR 159), hypotension (BP 90/45), hypoxia (SpO2 84% on RA), and febrile (temp 38.1). Patient was started on O2, IV access was obtained via nasal prong and brought to hospital.

09-10-2021 - 0346 – ER - Patient stabilized in the ED, arrived unaccompanied. Despite being oriented x3 after stabilization, patient has periods of restlessness and agitation. Patient has visible open fracture of Lt radial and ulnar bones. Patient refuses contact with family.

09-10-2021 – 0520 – Patient has sx for open fracture.

10-10-2021 – 0626 – PACU – Patient is febrile (temp 38.6), tachycardia (HR 122), tachypnea (RR 30), SpO2 95% on 5L nasal prongs. CXR shows left lower lobe pneumonia. Patient is started on IV antibiotics.

10-10-2021 – 0755 – Post-Operative Unit – Patient refuses care and is preparing to leave AMA.

Families for
Addiction Recovery

Poll 3

Do you think this patient has capacity to make treatment decisions related to their pneumonia?

Would you involve family?

Do you consider this patient a risk for harm to self?

Eating Disorders and Anosognosia

There is a recent Capacity and Consent Board case dealing with a 20-year-old patient who was found to lack capacity to make treatment decisions regarding her eating disorder.

She failed the test of capacity because she did not believe that she had an eating disorder and so could not appreciate the consequences of receiving or not receiving treatment.

Treatment was provided with consent of her SDMs

Does the Mental Health Act apply to SUD?

- Criteria (1) mental disorder? Yes
  - Diagnostic and Statistical Manual of Mental Disorders (DSM)
  - Consent and Capacity Board
- Criteria(2) serious harm? Yes
  - Can be “serious bodily harm” or “serious physical impairment”
- “Precedent-setting decisions support the legal opinion that substance use disorders can satisfy both the “mental disorder” and “harm” criteria in all provinces and that involuntary admissions for this population are possible under current legislations.”[6]

Families for
Addiction Recovery

Substance Use Disorders Affect Autonomy

Sunnyside Home v Ontario Nurses Association

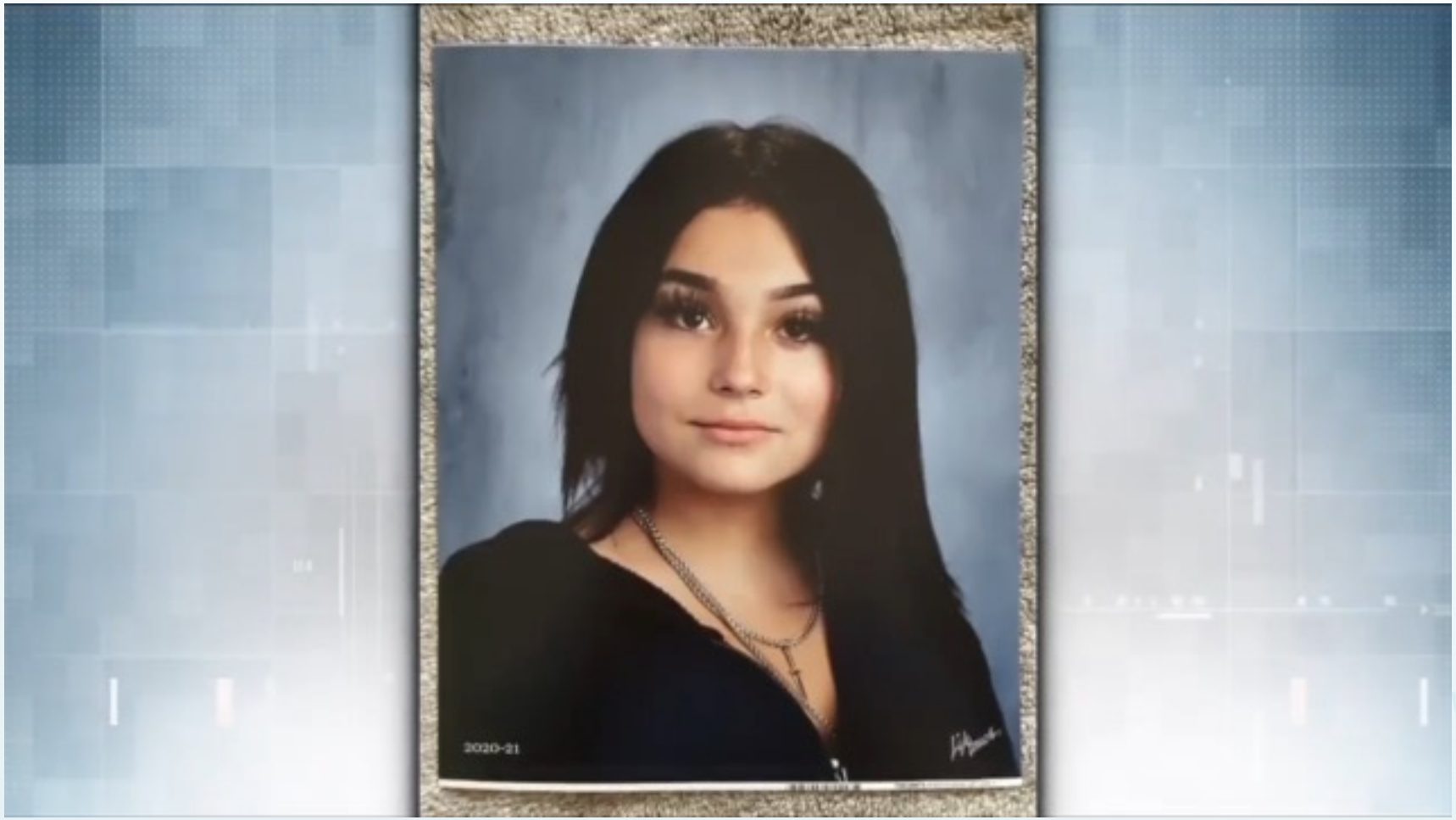
Substance use disorder is a disability under the Ontario Human Rights Code

Nursing home (employer) ordered to accommodate RN(employee)

"...I find that these substance use disorders are a mental disorder characterized by, among other things, compulsive behaviour and either a complete inability or a diminished capacity to resist the urge to engage in behaviour supporting her addiction."

Families for
Addiction Recovery

Ally Thomas,12, dies of 4th overdose in BC



Families for
Addiction Recovery

Human Rights Laws vs. Health Laws

Sunnyside illustrates that our human rights laws protect the livelihoods of functional employees because substance use disorders are a disability and have a detrimental effect on a person's autonomy. Yet our health laws, as drafted or applied, are not protecting the lives of youth with substance use disorders because of patient autonomy.

What is a Rights Based Approach?

Competing rights must be balanced

- Eg. where a person does not want to die, and their right to refuse treatment (autonomy) conflicts with their right to life and security of the person, which right should be prioritized?

According to the WHO and UN Committee on the UN Convention on the Rights of the Disabled, it's the right to refuse treatment

Families for Addiction Recovery

What is a Rights Based Approach for Minors?

The UN Convention on the Rights of the Child (UN CRC)[7]

- Article 3: Best Interests of the Child
- Article 24: Access to Health Care Facilities and Services
- Article 33: Right to be protected from the use of illegal drugs and from being used in the drug trade

University of Toronto Conference, 2009

- Putting the best interest of the child first would require significant changes in current models of formal health care
- Need strategies to keep young people out of the criminal justice system
- Codes of conduct by the colleges of health professionals on the best interests of the child[8]

Ways forward

- Improve understanding and application of health laws to SUD
- Recognize SUD as a mental disorder that affects autonomy and capacity to make treatment decisions
- Engage with all stakeholders regarding application of, and amendments to, health laws
- Provide person **and** family-centred care

Families for
Addiction Recovery

References

1. Copello, A. & Orford, J. (2002). Addiction and the family: is it time for services to take notice of the evidence? Addiction, 97, 1361-1363.

2. Forchuk, C. (2002). Therapeutic Relationships: From Hospital to Community. Ottawa: Canadian Health Services Research Foundation.

3. Sparks, S. N., & Tisch, R. (2018). A Family-Centered Program to Break the Cycle of Addiction. Families in Society, 99 (2), 100-109.

4. Stormshak, E., Caruthers, A., Chronister, K., DeGarmo, D., Stapleton, J., Falkenstein, C., DeVargas, & Nash, W. (2018). Reducing risk behavior with family-centered prevention during the young adult years. Prevention Science, 20(3).

5. Corrigan, P. W., Watson, A. C., & Miller, F. E. (2006). Blame, shame, and contamination: The impact of mental illness and drug dependence stigma on family members. Journal of family psychology, 20(2), 239-246.

6. Reid N, Chartier LB, Orkin A, Klaiman M, Naidoo K, Stergiopoulos V. Rethinking involuntary admission for individuals presenting to Canadian emergency departments with life-threatening substance use disorders. CJEM. 2020 Sep;22(5):629-632. doi: 10.1017/cem.2020.385. PMID: 32538339.

7. Secure care: a question of capacity, autonomy and the best interests of the child Angie L. Hamilton, Daphne G. Jarvis, Barbara E.L. Watts, CMAJ Feb 2020, 192 (5) E121-E122; DOI: 10.1503/cmaj.73252

8. Best Interests of the Child: Meaning and Implications in Canada, 2009