The **Douglas Mental Health University Institute** presents the **15th exchange session** within the **Cross-training program** on concurrent mental health and substance use disorders

Mental health, substance use and incapacity: Legal and ethical aspects of intervention with adult and elderly clienteles

Participant guide

Friday, November 25th, 2016

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Untitled
Collection Les Impatients

This activity is being held with the support of funding received by the *Molson Foundation*, the *Association des intervenants en dépendances du Québec (AIDQ)* and the *Academic Affairs, Teaching and Research Directorate of the Montreal West Island Integrated University Health and Social Service Centre*

Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'Île-de-Montréal
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What is "cross-training"?

Cross-training is an approach that is becoming increasingly used to improve the functioning of services within a network. The aim is to create a better understanding of the role of each partner to ensure an optimal continuity of services. Cross-training programs generally involve observational **personnel rotations** among different teams working with a same or similar clientele in order to allow professionals to learn more about other resources and different methods of intervention. This technique helps to enhance professional collaboration and also improves the continuum of services. Since 2007, **exchange sessions** have been added to the program, such as the one that you are attending today.

What does this 15th exchange session consist of?

The general objective is to:

- Define notions capacity, incapacity and consent;
- Address main legal and ethical aspects involved;
- Discuss evaluation and intervention methods as well as collaboration.

The exchange session that you are participating in today is composed of the following activities:

- Conferences and presentations;
- Group discussions based on case studies;
- Testimonies;
- A review of the day.

On behalf of all of the partners involved in the organization of this activity, I wish you an excellent exchange session!

Michel Perreault, Ph.D.

Who are the participants?

This exchange session brings together, via visioconference, participants from 21 distinct sites in the regions of Montréal (3), Mauricie/Centre-du-Québec (4), Outaouais (4), Ottawa (1), Abitibi-Témiscamingue (2), Montérégie (2), Quebec City (1) and Nord-du-Québec (4). In total, more than 500 professionals will be taking part in this day. These individuals come from the fields of geriatrics, psychiatry, substance abuse treatment, public health, school boards, as well as the network of services for public security. Also among us, and involved in the organization of the day, are professionals from establishments within the health network as well as alternative resources, community organizations, and universities.

Am I a model participant?

- The model participant responds to his or her primary needs (drinks, snacks, meals, washroom) within the time allotted for breaks, and respects the schedule;
- The model participant makes sure to turn off his or her cellphone, pager, tablet, gramophone, or telegraph before the beginning of the presentations;
- The model participant is happy to know that if he/she has mentioned having a food allergy in the registration form, there will be a lunch box with their name on it reserved for them at the registration table at the front of the Douglas Hall. If in doubt, please speak to Louise Bénard.

Acknowledgements

This activity is offered courtesy of funding received by the *Molson Foundation*, the Ass*ociation des intervenants en dépendances du Québec (AIDQ)*, and the *Academic Affairs, Teaching and Research Directorate - Montreal West Island Integrated University Health and Social Service Centre* and from the contribution of all resources that support the continued participation of their personnel. A special thank you to our collaborators from the CISSS de l'Outaouais and the addiction rehabilitation services of the CIUSSS de la Mauricie-et-du-Centre-du-Québec as well as to everyone who, once again, has generously accepted to participate in the organization of the day in the role of presenter, discussion group moderator or reporter, as well as those who have joined our research team in order to help support the event. Thank you!

Please address any questions or comments to our (superb and) fabulous team members:

Registration	Diana	514-761-6131, ext. 2829 diana.milton@douglas.mcgill.ca
Food and beverage	Louise	514 761-6131, ext. 3459 louise.benard@douglas.mcgill.ca
Coordination of the cross-training program	Léonie	514-761-6131, ext. 2835 Leonie.Archambault@douglas.mcgill.ca
Program in general	Michel	514-761-6131, ext. 2823 michel.perreault@douglas.mcgill.ca

Case study # 1 (adult): Alice, 21 years old

Alice arrives on a Sunday night at the addiction-emergency department, very intoxicated and agitated. She says that she has engaged in intranasal and inhaled cocaine use several dozens of times in the last 24 hours, while fulfilling an escort contract. She says that she has not slept or eaten during this period. She has bruises on her arms and a scratch on her face. She also has superficial cuts on her forearms, which seem to be self-inflicted. Alice is known to the addiction-emergency service, as she has already come in six times during the last year. She regularly consumes speed, cannabis and alcohol. She is followed in psychiatry for a borderline personality disorder and a generalized anxiety disorder.

Alice has no contact with her family. After having repeatedly asked for help for their daughter, who refused all services, her parents, feeling exhausted and powerless, cut all ties with her. Alice's social network is now limited to her boyfriend. From what Alice has said to the staff of the addiction-emergency, he seems to be involved in street gangs and pimping. He has a strong hold on Alice, being that she is very vulnerable, easily influenced and fears rejection.
Upon her arrival at the addiction-emergency, Alice shows signs of anxiety and is expressing suicidal thoughts. Her speech is confused, she is talking to herself and looks around with suspicion. She breathes quickly, is sweating profusely and mumbles that she would be better off dead.

A few hours after her arrival, Alice receives a call from her boyfriend and informs the staff that she is leaving to meet him. However, she has not yet slept and seems just as agitated and confused as when she first arrived. The staff tries to convince her to spend the night at the emergency and to contact her psychiatrist the next day, but Alice insists on leaving.

Discussion questions

1) Is the case of Alice representative of the clientele that you work with? (How many people agree?) ☐$_1$ All ☐$_2$ The majority ☐$_3$ The minority ☐$_4$ None

2) In your practice, in which way could you handle Alice's situation? Which actions could be taken, from a clinical standpoint?

3) What existing services or programs could be involved to help Alice and/or her entourage?

4) In your opinion, what could have been done to prevent the situation that Alice finds herself in?

5) If you were in Alice's shoes, what services would you like to be offered?

6) In an ideal world, if you had the ability to improve the current offer of services for concurrent mental health, substance use and incapacity, what would you suggest?

Case study # 2 (adult) : Max, 42 years old

The police receive a call regarding a man who is yelling and frightening people on the street. His words are repetitive, sometimes menacing, and of a religious nature. He bangs his head on the walls. The UPS Justice team arrives on site and comes into contact with him. He is able to disclose his identity, but is disoriented in time and space. He says that he lives with his parents and adds that they insult him, hit him, tell him that he is not intelligent, and want to force him into the hospital. Max refuses to let them communicate with his parents. He does not want to be taken to the hospital or to any mental health resources. He also refuses services from the CLSC.

After working hard to calm Max, the UPS-Justice team refers him to a crisis center. Max accepts to go temporarily, and after a few days, confides in a staff member. He says that he does not want to go to the hospital because of a premonition that he will die if he goes there. He explains that he was brought to the emergency department a few years ago and was referred for a psychiatric consultation, which he did not attend.

Max immigrated to Quebec with his parents at the age of 12. He says that he talks to God and reports having been brought to a priest to be delivered when he was young. It is difficult for the staff to separate what is real from what is delusion. He is afraid to leave the crisis center and fears that his parents will find him.

Max is in a very vulnerable state. He has no income, no proof of identity and no social network, other than his parents.

Discussion questions

1. Is the case of Max representative of the clientele that you work with? (How many people agree?) ☐1 All ☐2 The majority ☐3 The minority ☐4 None

2. In your practice, in which way could you handle Max's situation? Which actions could be taken, from a clinical standpoint?

3. What existing services or programs could be involved to help Max?

4. In your opinion, what could have been done to prevent the situation that Max finds himself in?

5. If you were in Max's shoes, what services would you like to be offered?

6. In an ideal world, if you had the ability to improve the current offer of services for concurrent mental health, substance use and incapacity, what would you suggest?

Case study # 1 (elderly): Mr. St-Arnaud, 69 years old

Mr. St-Arnaud is well-known among services for addiction and homelessness, since his unstable lifestyle has brought him to make use of these services for many years. Before, he would often sleep at friends' homes, but he has become more and more isolated socially and he increasingly stays at shelters. He consumes 24 beers daily and eats very little (he mainly eats fast food). He has diabetes and hypertension. He sees the doctor when he is brought to the emergency department for severe problems, but does not show up for follow-up appointments. Also, he no longer takes his medication. He has spent numerous short periods in jail for theft and unpaid tickets.

At the beginning of the month of September, Mr. St-Arnaud, 69 years old, shows up at a shelter to eat and sleep. He is confused and aggressive. The nurse that evaluates him notices that he has lost weight and detects a serious abscess on his left leg. She wants to orient him to the emergency department for further evaluation and treatment of his wound. Mr. St-Arnaud firmly refuses, does not allow the nurse to examine him more thoroughly, and ignores the seriousness of not treating his wound. The staff members of the shelter determine that he is at immediate risk, and in accordance with law P-38, they decide to call the police. Upon their arrival, Mr. St-Arnaud is agitated and is furious with the staff of the shelter. The police manage to convince him to go to the hospital.

Upon arrival at the hospital, Mr. St-Arnaud is placed in protective custody. The treatment team wishes to proceed with a surgical treatment for his wound, which Mr. St-Arnaud refuses. The team proposes other, less invasive techniques, such as controlling his diabetes and alcohol consumption. He develops a good rapport with the treatment team and accepts to stay at the hospital beyond the duration of his protective custody. His mistrust and confusion diminish, and he accepts to receive a surgical intervention for his wound.

His hospitalization lasts for a month, and contributes to an improvement in his physical and mental condition. When the treating physician begins talking about his imminent release, the patient says that he wants to return to his old lifestyle. The evaluation by the psychiatrist concludes that the patient is capable of deciding what he would like to do upon his release, while the evaluation of the geriatrician brings into question his capacity to understand the risks involved and suggests that an order be made for housing.

Discussion questions

1. Is the case of Mr. St-Arnaud representative of the clientele that you work with? (How many people agree?)
   ☐1 All ☐2 The majority ☐3 The minority ☐4 None
2. In your practice, in which way could you handle Mr. St-Arnaud's situation? Which actions could be taken, from a clinical standpoint?
3. What existing services or programs could be involved to help Mr. St-Arnaud?
4. In your opinion, what could have been done to prevent the situation that Mr. St-Arnaud finds himself in?
5. If you were in Mr. St-Arnaud's shoes, what services would you like to be offered?
6. In an ideal world, if you had the ability to improve the current offer of services for concurrent mental health, substance use and incapacity, what would you suggest?

Case study #2 (elderly): Mrs. Létourneau, 74 years old

Mrs. Létourneau lives alone in the apartment that she shared with her husband before his death. She has always been anxious, but her condition has worsened since his passing, a year ago. She takes a lot of medication to control her anxiety and to sleep (ativan, valium), which is prescribed to her by two doctors, and which she obtains from two different pharmacies. Mrs. Létourneau also consumes alcohol (2 cinzanos every night before her meal, as well as wine at supper if she is hosting guests).

Since a few weeks ago, Mrs. Létourneau's sister has noticed that she has been saying odd things and has started to neglect the upkeep of her home. She tells herself that her sister might be beginning to have Alzheimer's and offers to accompany her to her next medical appointment, in two months. During this time, she communicates with the CLSC to ask for an evaluation and home care assistance. However, when the social worker of the CLSC arrives at her home, Mrs. Létourneau refuses the evaluation and any services. She claims that her sister wants to "take her money by making her look like a crazy person." She easily avoids questions intended to evaluate her judgment as well as her temporal/spatial orientation, and maintains articulate conversation, despite the paranoid elements. The social worker notices that she is agitated and that she has a cut on her face. Mrs. Létourneau says that she does not remember getting hurt. The social worker worries about her safety at home. She suggests that a nurse from the CLSC visit her, but she refuses completely.

When the social worker leaves her home, the landlord of the apartment flags her down to let her know that Mrs. Létourneau has not paid her rent for several months and he is ready to cut the electricity in her home.

Discussion questions

1) Is the case of Mrs. Létourneau representative of the clientele that you work with? (How many people agree?)

   ☐1 All ☐2 The majority ☐3 The minority ☐4 None

2) In your practice, in which way could you handle Mrs. Létourneau's situation? Which actions could be taken, from a clinical standpoint?

3) What existing services or programs could be involved to help Mrs. Létourneau and her entourage?

4) In your opinion, what could have been done to prevent the situation that Mrs. Létourneau finds herself in?

5) If you were in Mrs. Létourneau's shoes, what services would you like to be offered?

6) In an ideal world, if you had the ability to improve the current offer of services for concurrent mental health, substance use and incapacity, what would you suggest?

Where to find your discussion group

- **Groups # 1 à # 6 : Basement of Douglas Hall**
- **Groups # 7 à # 10 : Bowerman room in the Dobell pavilion**
- **Group # 11: Room K-3325, 3rd floor of the Porteous**
- **Group #12 : Maurice-Forget room, 2nd floor of the Douglas Hall**
- **Group # 13 : Gaston-Harnois room, 2nd floor of the Douglas Hall**
- **Atelier # 14 : Room K-3223, 3rd floor of the Porteous pavilion**
- **Atelier # 15 : Salle K-0147.2, Basement of the Porteous pavilion**
- **Atelier # 16 : Salle K-3225, 3rd floor of the Porteous pavilion**
- **Atelier # 17 : Salle K-3126.2, 3rd floor of the Porteous pavilion**

How to get to the Porteous pavilion?

From inside: Descend to the basement of the Douglas Hall and follow the arrows. The permanent directions and signs may also be useful for you to follow. Room K-0147.2 is in the basement hallway, passed the elevator. On the 3rd floor, **room K-3223 and K-3225** are in the **B wing**. **Room K-3126.2** is located in the **A wing**. **Room K-3325** is in the **C wing**.

From the outside: Exit the Douglas Hall through the main doorway. Follow the pathway on your right and then turn right. The Porteous Pavilion can be found on your left, after the Emergency Pavilion. When you enter the Porteous Pavilion, you must wait for the first set of glass doors inside the building to close completely before you will be able to open the second set of glass doors to take the elevator. You can also use the stairs through the door on your right. Room **K-0147.2** is in the basement hallway. On the 3rd floor, **room K-3223 and K-3225** are in the **B wing**. **Room K-3126.2** is located in the **A wing**. **Room K-3325** is in the **C wing.**

Return to the auditorium of the Douglas Hall at 2:00 pm. Please be on time!