A Values-Based Analysis of Recovery-Oriented Practice in Mental Health Care and Medical Assistance in Dying

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ABSTRACT

The Criminal Code of Canada has been amended to allow medical assistance in dying (MAiD) under prescribed criteria. There has been considerable debate regarding whether people with mental illness as the sole underlying medical condition should be eligible. It is argued that access to MAiD is not compatible with recovery-oriented care. Based on a comprehensive analysis exploring the ethical principles guiding decision making around MAiD, this paper offers a discussion of the compatibility between MAiD and recovery-oriented care and demonstrates significant overlap of these principles. The discussion around MAiD as an option in recovery-oriented care is legitimate and needs to continue.

Keywords: ethics, mental health, recovery, medical assistance in dying

RÉSUMÉ

Le Code criminel du Canada a été amendé pour autoriser l'assistance médicale à mourir (AMM) selon certains critères. Nombre de débats ont eu lieu quant à savoir si les personnes atteintes uniquement de maladie mentale pouvaient être considérées comme éligibles à l'AMM. L'incompatibilité de l'AMM avec les soins axés sur le rétablissement fait l'objet de nombreuses discussions. Fondé sur une analyse exhaustive des principes éthiques guidant la prise de décision autour de l'AMM, cet article propose une discussion sur la compatibilité entre l'AMM et les soins axés sur le rétablissement tout en démontrant un chevauchement important entre les deux. Le débat autour de l'AMM comme une option parmi les soins axés sur le rétablissement est légitime et se doit d'être poursuivit.

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Mots clés : éthique, santé mentale, rétablissement, aide médicale à mourir

As a result of Canada's decision to amend the Criminal Code allowing medical assistance in dying (MAiD) under prescribed criteria, there has been much debate and concern about how this shift will impact vulnerable and marginalized populations, such as those struggling with mental health issues. Allowing people with mental illness as the sole underlying medical condition the right to request MAiD continues to generate considerable debate, which has focused on a few key arguments: (1) the concern that people living with mental illness do not have the capacity to consent to MAiD or that their capacity cannot be accurately assessed; (2) that people with mental illness are vulnerable and in need of protection; (3) all physicians, particularly psychiatrists, have an ethical obligation to "do no harm" and to prevent suicide at all cost and, therefore, are not socialized to the act of intentionally hastening death; (4) there are no mental illnesses that can be determined to be incurable and no suffering from mental illness that can be determined to be irremediable; and (5) the recovery philosophy of care in mental health is not compatible with the provision of MAiD services. Recent papers have examined the first four arguments in detail (Blikshavn, Husum, & Magelssen, 2017; Charland, Lemmens, & Wada, 2016; Dembo, Schuklenk, & Reggler, 2018; Doernberg, Peteet, & Kim, 2016; Downie & Dembo, 2016; Kim & Lemmens, 2016; Lemmens, 2016; Maher, 2017; Rooney, Schuklenk, & van de Vathorst, 2017; Shaffer, Cook, & Connolly, 2016; Sheehan, Gaind, & Downar, 2017). This paper will explore the compatibility of a recovery model of care with the provision of MAiD services in mental health. Given that MAiD is now a reality in Canadian society, we have generated critical assumptions and ethical tensions, which are described in Table 1.

BACKGROUND

In 2016, Bill C-14 was implemented, allowing Canadians meeting prescribed eligibility criteria to receive access to MAiD. In 2019, the Superior Court of Québec ruled that it was unconstitutional to limit access to MAiD to people nearing the end of life (*Truchon v. Procureur Général Du Canada*, 2019). The Government of Canada accepted the ruling and currently plans to change the federal law. This, along with the upcoming 5-year review of the MAiD law and pending decisions about eligibility of vulnerable populations, has implications for healthcare organizations which will need to update their practices, policies, and procedures accordingly. Ethical discussion and analysis are needed to support organizational decisions.

An ethics-based analysis of MAiD undertaken by the Joint Centre for Bioethics at the University of Toronto advanced the position that consideration of the broad ethical tensions, dimensions, and implications of implementing MAiD would greatly assist in resolving such dilemmas (Incardona, Bean, Reel, & Wagner, 2016). Six overarching substantive and procedural ethical principles were identified to provide ethics-based guidance for a wide range of stakeholders. These principles are accountability, collaboration, dignity, equity, respect, and transparency which are described in Table 2.

Although these are not the same principles as those underlying the recovery philosophy of care in mental health (Figure 1), there is significant overlap. The recovery model of care has been recommended

Table 1

Assumptions and Ethical Tensions Underlying the MAiD and Recovery-Oriented Practice Debate

Assumptions
• Society has collectively, though not unanimously asked for MAiD as an end-of-life care option in Canada, however healthcare practitioners are still not fully socialized to consider either MAiD or the act of intentionally hastening death as an option, particularly in mental health.
• While debate may persist about the practice of MAiD and mental illness, eligible residents of Canada are nonetheless able to legally request MAiD.
• Patients with a mental illness are not automatically incapable of making end-of-life decisions.
• When a patient makes a request for MAiD, hastened death is only one possible outcome of that request. Enhancing palliative care access, supports, and services will help address the concerns of the majority of patients, including those seeking MAiD.
• MAiD can be a rational request.
• The number of patients who make inquiries about MAiD exceed those who make a formal request for MAiD.
• A small subset of people with mental illness have incurable conditions and irremediable suffering.
• Recovery is patient-centred and non-paternalistic.
Ethical Tensions
• Whether healthcare practitioners support or conscientiously object to providing MAiD services to service users, there should be systems in place to ensure they are supported by the healthcare provider community and society. Accordingly, employers, professional associations and others must appropriately plan, resource, and institute proactive support systems for both patients and healthcare practitioners.
• Reconciling the ethical obligation for physicians and other healthcare practitioners to "do no harm" and a duty of non-abandonment with the obligation to respect patient autonomy and potentially hasten death if MAiD eligibility criteria are met.
• Adopting safeguards to mitigate potential risk of harm to the mental health population without creating unreasonable access barriers.

as the model of mental health service delivery in Canada (Mental Health Commission of Canada, 2015). Unlike the medical model of care, in which "recovery" is described as the absence of symptoms, recovery in mental health care does not require people to experience reduced symptoms, but to regain control of their life despite the illness (Shepherd, Boardman, & Slade, 2008). However, there is not one particular recovery model adopted across Canada. Therefore, for the purposes of this paper, the most rigorous and widely accepted model was used. A systematic review using inductive thematic analysis to identify common themes across 30 recovery-oriented practice guidelines from six countries identified four domains of recovery-oriented practice: promoting citizenship, organizational commitment, working relationship, and personal recovery (Le Boutillier, Leamy, Bird, Davidson, Williams, & Slade, 2011). A number of frameworks and models have been developed that apply the final practice domain, "supporting personally defined recovery." The CHIME framework, named for the dimensions of personal recovery listed below, was rigorously developed based on a systematic review of 97 papers examining personal recovery (see Figure 1). The dimensions of personal recovery are (a) connectedness, (b) hope and optimism about the future, (c) identity, (d) meaning in life, and (e) empowerment (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Despite this comprehensive framework, "recovery" in mental health is often interpreted singularly as fostering hope, when in

Table 2

Overarching Ethical Principles and Associated Goals

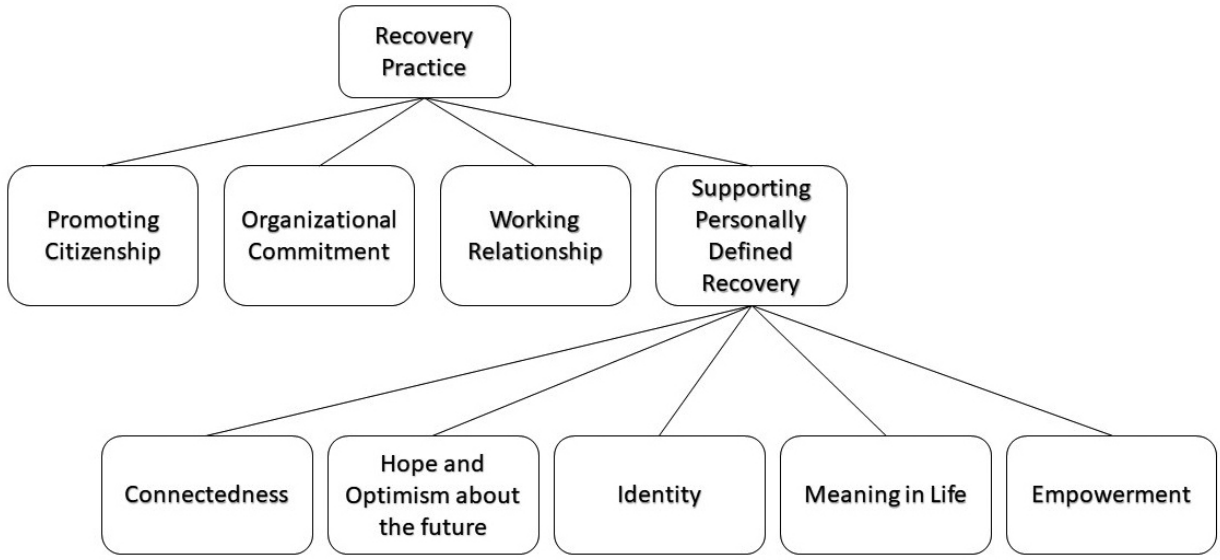
Principle	Associated Goal(s)
Accountability	Implement MAiD in a manner that clearly identifies lines of authority, an oversight mechanism and associated responsibilities for all relevant stakeholders, including boards of directors, patients, their families, healthcare professionals, professional colleges and associations, and policy makers such that pubic trust in the process is preserved and enhanced.
Collaboration	Build, preserve, and strengthen inter-professional, inter-institutional, inter-sectoral, and where appropriate, inter-provincial/territorial collaborations and partnerships to facilitate consistent implementation of MAiD. Partner to collectively establish evidence-based best practices.
Dignity	Recognize and preserve the inherent worth of each person and their individual experience of pain and suffering and associated decisions across the life continuum.
Equity	Promote fair and just access to MAiD for all eligible individuals irrespective of healthcare setting or geographic area. Support procedural fairness such that similar MAiD cases are treated in a similar manner and dissimilar MAiD cases are treated in a manner that takes into account the differences.
Respect	Demonstrate the highest regard for persons, organizations, and their associated beliefs and values related to MAiD and the myriad of concepts, issues and practices associated with it.
Transparency	Foster and maintain public, patient, and healthcare provider trust and confidence in health system.

Note. Adapted from Incardona et al., 2016, p. 7.

fact “hope” is one of five components of personal recovery. This paper presents a comprehensive ethical analysis examining the compatibility of the principles of recovery-oriented care with the ethical principles laid out by the Joint Committee for Bioethics to guide decision making around MAiD. (Table 2).

Figure 1

An Overview of Recovery-Oriented Practice



A COMPARISON OF PRINCIPLES UNDERLYING RECOVERY-ORIENTED PRACTICE IN MENTAL HEALTH CARE AND MAID

Based on the analysis above, the following sections illustrate the overlap between recovery-oriented practice and the ethical principles identified to guide decision making around MAiD.

Promoting Citizenship

The first practice domain, "promoting citizenship," encourages the provision of services and advocacy to support people with mental illness to live and participate in society as equal citizens (Le Boutillier, et al., 2011). As equal citizens, it is important to recognize and preserve the inherent worth of each person and their experience of pain and suffering along with the decisions they make for their healthcare, as outlined in the MAiD principle of dignity. Analogous to the promoting citizenship recovery practice domain, the MAiD principle of dignity supports "creating an environment that respects individual values and autonomy," and even for individuals ineligible for MAiD, there is an obligation to provide the appropriate care and support. This domain also overlaps with the MAiD principles of equity and respect. People living with mental illness should have the same rights and responsibilities as any other citizen to request access to MAiD. Persons should not be assumed incapable to consent based on the label of a mental illness. Providing a fair assessment free of stigma to determine their eligibility would ensure that the ethical principles of dignity, equity, and respect are met and service provision is recovery-oriented.

Organizational Commitment

The second practice domain, "organizational commitment," states that facilities should ensure that the work environment and service structure facilitate and enable the practice of recovery-oriented care (Le Boutillier et al., 2011). This domain overlaps with the MAiD principles of accountability, transparency, and collaboration. Organizations that subscribe to recovery-oriented practice should have policies in place to enable service users to access services to support them while pursuing their personal goals and should be transparent when disclosing the types of services offered. As there is no restriction on making a formal request for MAiD, healthcare organizations are responsible to have processes in place to respond to such requests in a meaningful way, whether or not the requesting service user is eligible. Organizations must provide supports to enable service users to access information to explore all options and make an informed choice regarding whether or not to formally initiate a request for MAiD. Having appropriate processes also includes having safety measures in place, for example, eligibility assessments including capacity assessment, qualified personnel for second opinions, and other safeguards to ensure access to MAiD is only provided where appropriate. Healthcare professionals require specialized education and training to support the service user throughout the MAiD request. This process will require collaboration at all levels: within professions, between professions, and within organizations.

Working Relationship

The third practice domain, "working relationship," is defined as a strong therapeutic alliance essential to recovery (Le Boutillier et al., 2011). Practitioners must respect the service user's wishes in order to support them and their families to shape their own future. This third practice domain is strongly aligned with the MAiD principles of transparency and collaboration. Therefore, when a service user inquires about MAiD, the practitioner should be able to have a transparent and fully informed conversation about risks, benefits, side effects, and alternatives. MAiD is meant to be a careful and thoughtful process during which a healthcare professional (i.e., medical practitioner or nurse practitioner) carefully assesses the service user to determine that the request is well-reasoned and founded on a capable decision to end suffering (Berghmans, Widdershoven, & Widdershoven-Heerding, 2013). An optimal working relationship will ensure that all potential resources and treatment options are identified, exhausted, or at least seriously considered prior to provision of MAiD services. The respect demonstrated through these collaborative and transparent interactions aligns with the ethical principles supporting MAiD with this recovery domain.

Supporting Personally Defined Recovery

The CHIME framework identifies five dimensions of personal recovery (Leamy et al., 2011). This framework is often misunderstood as meaning that personal recovery must have equal parts of each of the five dimensions, or alternatively, the focus is solely on hope. However, personal recovery is individually defined and each dimension or principle will carry a different "weight" or importance for each individual and an individual's definition of their own recovery may fluctuate over time.

Connectedness. Connectedness refers to relationship building, support from peers, groups, friends, family or others, and being part of the community (Leamy et al., 2011). The collaborative process of MAiD

aligns with the recovery-oriented practice of connectedness by allowing all Canadians to feel safe and respected to request MAiD information without being judged or stigmatized. This is in contrast to the isolation currently experienced by people with mental illness when contemplating ending their lives. The request for MAiD is not always accompanied by a genuine desire to die, but may signal a request for help in a life that has become difficult, complicated, and painful (Coyle & Sculco, 2004). An honest, transparent conversation between the service user and healthcare practitioner about the possibility of MAiD that explores all available service and care options can demonstrate respect for the service user and strengthen the therapeutic relationship and feeling of connectedness, even if the service user does not meet MAiD eligibility criteria.

Hope and optimism about the future. This includes the motivation to change, develop hope-inspiring relationships, positive thinking, valuing success, and having dreams and aspirations (Leamy et al., 2011). This dimension of personal recovery does not have clear overlap with the MAiD principles; however, this paper offers alternate ideas of hope and optimism for consideration.

Slade (2012) defines hope as believing in oneself and having a sense of personal agency. One of the most prominent arguments against offering MAiD to people with mental illness as the sole underlying condition is the claim that offering MAiD robs the person of hope and optimism about the future. The reality of both hope and optimism is that there are many different ways to perceive and define each of those terms both separately and together (Schrank, Stanghellini, & Slade 2008; Whitley 2010). Hope is not a singular phenomenon (McCormack et al., 2016) and how one perceives hope and optimism are complex and individualistic. Each individual will develop their unique definition based upon personal beliefs, values, and context. Hope and optimism may take on different forms, for example, a state of mind, a component of empowerment, or an expectation. While some people with mental illness may hope for recovery, others may hope for dignity in life or death, understanding or internal peace, access to care, or equitable treatment. The pathway to any of these outcomes will be unique. This acknowledges the therapeutic significance of hope and optimism but not in a prescriptive way.

Identity. The recovery dimension of identity involves re-establishing a positive identity and overcoming stigma (Leamy et al., 2011). Re-establishing a positive identity includes the service users establishing themselves as the autonomous leaders of their lives rather than being simply a passive recipient of care (Shepherd et al., 2008). The act itself of requesting MAiD can demonstrate great autonomous leadership in care and assertion of identity. There is overlap with the ethical principles of dignity and respect underlying MAiD. However, the connection with the second part of the dimension, "overcoming stigma," is stronger.

Overcoming stigma is an aspirational goal that may be out of reach. Although we may not be able to overcome stigma, this may be a step towards managing stigma. As discussed previously, refusing access to MAiD to the entire mental health population, aligns with neither recovery philosophy nor the principles of dignity, equity, and respect that underlie MAiD. Further, it continues to marginalize and stigmatize this population as vulnerable and incapable of making healthcare decisions (Downie & Dembo, 2016; *Starson v. Swayze,* 2003).

Meaning in life. The next dimension encompasses an individual's perception of meaning in life. Depending on the individual, this may involve finding meaning in the experience of mental illness, spirituality, quality of life, meaningful life and social roles and/or goals and rebuilding life (Leamy et al., 2011). Although there may not be substantial overlap, the MAiD principle of dignity aligns with parts of this recovery

dimension particularly when considering quality of life, social roles, and/or goals. Service users have explained that their illness has made them feel trapped in their suffering. For some people, having the choice to request MAiD may allow a recovery of dignity and a respect for the autonomy of the person to decide.

Spirituality and religion have been shown to be associated with purpose in life (Young, Cashwell, & Woolington, 1998). Death is the inevitable end to life and the rituals and thoughts around it are often tied closely to spirituality. The choice to request MAiD may enable some service users to align their end-of-life decisions with their spiritual beliefs and/or values, supporting their dignity in life up to and including death.

Empowerment. The final personal recovery dimension is empowerment, which is defined in two parts: first, as an individual taking responsibility and control of their life and illness and second focusing recovery on their personal strengths (Leamy et al., 2011). The principles of MAiD do not appear to align with the second part of the definition, which focuses more on skills; however, the first part of empowerment is directly aligned with the ethical principles of respect for autonomy and self-determination and supports the service user to be more accountable for their recovery journey. For instance, choice of access to MAiD could support enhanced service user control over their recovery options and lives; people with terminal illnesses who have requested MAiD have had the prescription filled, but did not use the medications intended to hasten death (*The Economist*, 2015; Thienpont, Verhofstadt, Van Loon, Distelmans, Audenaert, & De Deyn, 2015). Service users have explained that requesting MAiD allowed them to feel less trapped and better in control of their lives, which in their view was a reason not to follow through with MAiD (*The Economist*, 2015; Centre for Addiction and Mental Health, 2017). In addressing this principle, empowerment and self-determination can be exercised by a service user requesting MAiD and then making their own decisions regarding whether or not to follow through with its provision.

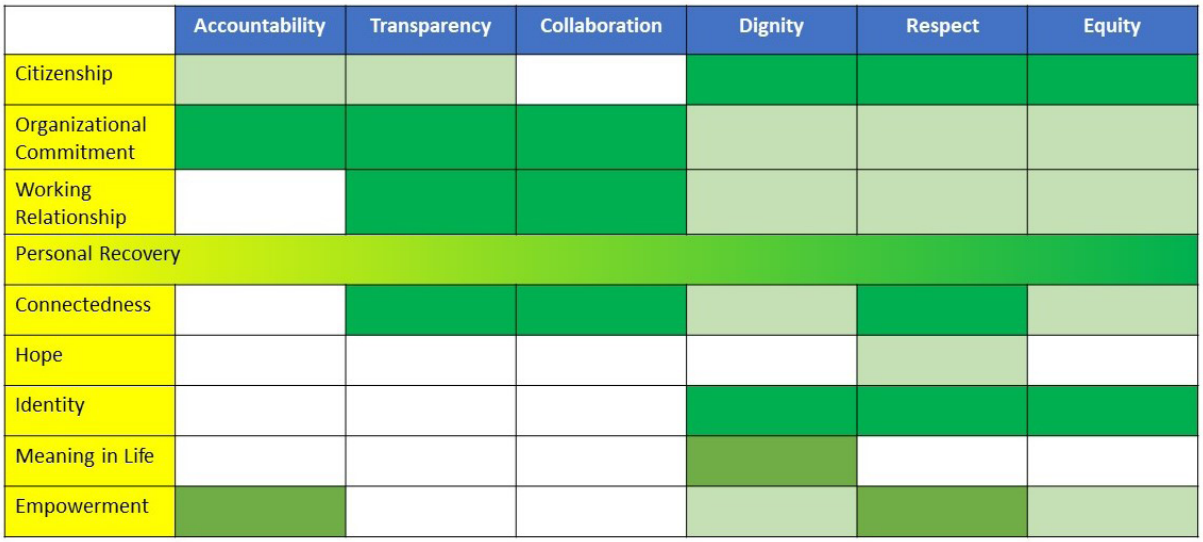
CONCLUSIONS

Although the principles of MAiD and recovery do not entirely overlap, this article demonstrates that recovery-oriented practice does not inherently exclude MAiD (Figure 2). For many people it is difficult to understand how MAiD, a life-ending intervention, is compatible with recovery-oriented care. The assumption in this paper is that restricting the mental health population from accessing MAiD not only limits choice, autonomy, and control in life, but is also stigmatizing because the assumption is that everyone with a mental illness is vulnerable and incapable of making such a decision (Walker-Renshaw & Finley, 2016). The criteria to assess and the procedure to implement MAiD may necessarily be different for the persons with mental illness as the sole underlying cause for their request, but it should remain procedurally fair and non-discriminatory. MAiD requests within this population are challenging to assess; however, the complexity and controversy surrounding these cases should not exclude this population from accessing services available to other citizens.

Figure 2 summarizes the overlap between the principles underlying MAiD and recovery and suggests that there is a legitimate option for MAiD in recovery-oriented care. The discussion needs to continue in a holistic manner and must include strategies to evolve services to support mental health patients suffering from irremediable illness. This will ensure they have the same options as other populations and that they can exercise these options, including end-of-life care.

Figure 2

Heat Map Showing the Overlap between the Principles Supporting Decision-Making for Medical Assistance in Dying and Recovery-Oriented Practice



Note. Gradient from white (suggesting little-to-no overlap) to dark (suggesting significant overlap).

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