Psychiatric Patient Advocate Office

Annual Report
2010

Rights Protection in a Time of Change

Psychiatric Patient Advocate Office

Bureau de l'intervention en faveur des patients des établissements psychiatriques

October 28, 2011

The Hon. Deb Matthews
Minister of Health and Long-Term Care
10th Floor Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister Matthews:

I am pleased to submit the 2010 Annual Report of the Psychiatric Patient Advocate Office (PPAO). It is submitted in accordance with the Memorandum of Understanding between the PPAO and the Ministry of Health & Long-Term Care, and reflects the PPAO's arm's length relationship with the Ministry in executing its advocacy and rights protection mandate.

This report, spanning the period from January 1, 2010 to December 31, 2010 captures:

- the delivery of advocacy and rights advice services to persons with mental illness in the ten tertiary care psychiatric hospitals;
- the delivery of rights advice in 57 of 61 additional Schedule 1 psychiatric facilities; and
- the provision of rights advice to a growing number of individuals subject to Community Treatment Orders who are living in the community.

We strongly believe that, in promoting and protecting the rights of the vulnerable Ontarians we serve, we help to mitigate the stigma and discrimination they experience and support their full social inclusion and citizenship. For this reason, we take great pride in the balance our program continues to bring to the mental health system, as we approach nearly three decades of continuous service.

Respectfully submitted,

Vahe Kehyayan
Director

cc. Saad Rafi, Deputy Minister of Health & Long-Term Care
David Hallett, Associate Deputy Minister
Patricia Li, Assistant Deputy Minister

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Director’s Message

I am pleased to submit the Annual Report of the Psychiatric Patient Advocate Office (PPAO) for 2010 to the Minister of Health and Long-Term Care. Once again, this Report attests to PPAO’s unflagging commitment to protecting the rights and entitlements of persons with mental illness.

Drawing on both the professional literature and nearly three decades of continuous service, we have little doubt that advocacy is a critical component in a comprehensive mental health system, insofar as it promotes the highest quality of care and quality of life for the vulnerable Ontarians we serve. *The Excellent Care for All Act, 2010,* which was proclaimed in 2010, puts patients first and aims to improve the quality and value of the patient experience through the application of evidence-based health care. However, in contrast, the government’s comprehensive mental health and addictions strategy, “Open Minds, Healthy Minds, released in June, 2011, does not stipulate a role for patient advocacy, which is fundamentally a client-centered support.

The PPAO has arrived at a critical juncture in its history, and so has mental health advocacy in Ontario. We welcome the opportunity to collaborate with the Ministry, mental health consumers, and community stakeholders in designing a mental health advocacy service that is integral to Ontario’s mental health system and places consumers squarely at the centre of their own healthcare.

Vahe Kehyayan, Director
Psychiatric Patient Advocate Office

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What does the PPAO's Logo Mean?

Our logo, with its three segments, places the client at the center, with the advocate and the client's support network on either side. In our practice of advocacy, we at the PPAO proceed from the client's perspective, the heart of the matter. We believe that creating caring systems requires the effort of all those involved.

The relationship between advocates and their clients is very unique. These clients are vulnerable because of their illness. Patient Advocates are partisan advocates for their clients. The advocate-client relationship is fiduciary in nature—it is based on complete trust and confidence.

We chose the heart symbol as our logo because it best reflected our vision, values and principles:

That consumers of mental health services be treated with dignity and respect;

That consumers of mental health services be actively involved in all decisions affecting their life, care and treatment;

That consumers of mental health services direct the advocacy process, using the advocate as a resource;

That advocates respect each client's personal choices, providing advocacy from the client's point of view.

Our Mission

We protect and promote the rights and entitlements of Ontarians with mental illness through advocacy, rights advice and education.

Our Vision

We envision a society where the rights of all individuals regardless of mental illness or disability are respected, protected and realized.

Our Mandate

To advance the legal and civil rights of patients by means of both individual case work and systemic advocacy;

To inform the patient, family, hospital staff, and the community about patients' legal and civil rights;

To assist, facilitate (self-advocacy), and help resolve the complaints made by psychiatric patients by providing an avenue for resolution through negotiation according to the patient's instructions;

To investigate alleged incidents and to assess institutional and systemic responses to these instances;

To refer patients, when necessary, to outside community advocacy resources such as community organizations, lawyers or physicians who may offer a second opinion.

Profile of Services

The Psychiatric Patient Advocate Office (PPAO) was established in May 1983 to provide independent advocacy and rights protection services to patients in the ten, now divested, provincial psychiatric hospitals (now called tertiary care psychiatric hospitals) and to advise the Minister of Health and Long-Term Care on mental health matters from a rights perspective. As an arm's length program of the Ministry of Health and Long-Term Care, the PPAO operates under a Memorandum of Understanding, which sets out its mandate and accountability relationship to the Ministry. In carrying out its advocacy and rights protection mandate, the PPAO does not speak on behalf of the Ministry.

> **"Each core service plays a key role in protecting and promoting the rights of individuals with mental illness."**

The PPAO protects and promotes the rights and entitlements of Ontarians with mental illness by providing four core services: rights advice, individual advocacy, systemic advocacy, and public education and community engagement. Each core service plays a key role in protecting and promoting the rights of individuals with mental illness and in promoting systemic change that improves the quality of care, life, treatment and recovery of individuals with mental illness in Ontario.

We envision a society where the rights of all individuals regardless of mental illness or disability are respected, protected and realized. As champions of the rights of mental health consumers, our services are guided by the following core values and beliefs:

- people can and do recover from mental illness
- people have the right to pursue personally defined goals for recovery and well-being
- advocacy and rights protection play vital roles in recovery and continued health and well-being
- advocacy is most effective when it is independent and free from actual or perceived conflicts of interest
- people can function and live in the communities of their choice with adequate supports and services
- people have the right to access effective services which are both needed and wanted
- consultation with consumers is essential to building responsive and effective services
- people have the right to information that is necessary to make informed choices
- people have the right to be involved in all decisions affecting their care, treatment and lives

At the heart of what we do rest these beliefs, all of which are aligned with our stake around rights, empowerment and recovery. As participants in our clients' lives we strive to restore them to full participation and membership in the community at large.

Rights Advice

Rights advice is a process by which patients in psychiatric facilities, individuals in the community who are being considered for a Community Treatment Order (CTO) and their substitute decision-maker, if any, are informed of their rights when their legal status has changed. Rights advice is an important component in the system of checks and balances established under the *Mental Health Act* and its regulations for the protection of the rights of the individual. Rights Advice is required in nine mandatory situations. The Rights Adviser explains the significance of the form to the client, discusses the options available, and upon request, assists the client to apply for a hearing before the Consent and Capacity Board, to obtain a lawyer, and to apply for Legal Aid.

By definition, a Rights Adviser may not be involved in the direct clinical care of the client or provide treatment or care and supervision to that person under a community treatment plan. Rights Advisers must meet the qualifications specified in the regulations to the *Mental Health Act*, including successful completion of a training program for Rights Advisers approved by the Minister of Health and Long-Term Care. The PPAO's training program has been so approved.

The relationship between the Rights Adviser and the client is unique. In circumstances where the client may feel powerless, the Rights Adviser provides a neutral and non-judgmental presence. The Rights Adviser is not part of the clinical team and does not make decisions for the patient. In fact, the Rights Adviser may only act upon a client's request or specific instruction. The Rights Adviser must provide the client with the best possible opportunity to understand the information provided. In some cases a second and subsequent visits may provide this opportunity.

Advocacy

Advocacy is a process that ensures that the rights of vulnerable people are protected, that their self-defined needs are met, and that they are supported to make decisions that affect their care, treatment, and lives.

Advocacy is both essential and integral to a reformed mental health system, which strives toward a comprehensive and seamless system of care, treatment and support. Advocacy, whether provided in community or hospital, empowers and assists consumers in addressing quality of care, life and rights-based issues arising from their treatment and rehabilitation.

Partisan advocacy, as defined by the PPAO, begins with the client's perspective and instruction and supports self-identified goals and needs. It seeks to increase the range of choices for clients at the levels of both the individual and the system.

This view of advocacy is compatible with a recovery-oriented framework, which at its heart seeks to empower consumers to assume increased responsibility and decision-making authority with respect to their care, treatment and rehabilitation.

Advocacy seeks to assist or empower clients to resolve concerns through a range of education, negotiation, facilitation and conflict resolution strategies. Clients are free to determine the amount of assistance they need from the Patient Advocate. Some may decide to advocate for themselves with limited support from the Patient Advocate. Others may rely fully on the advocate to articulate their concerns or to strengthen their voice in expressing concerns.

Advocacy undertaken on behalf of individual clients is either instructed or non-instructed and provides support across a variety of environments including hospital and community.

As shown in Figure 1, the PPAO views advocacy as a continuum of activities ranging from the simple act of giving information to the more complex act of advocating with or on behalf of a client. At the far left, Patient Advocates provide ongoing information to clients, families, staff of psychiatric facilities, health and social service practitioners, ministries, and the general public on matters relating to patient rights and mental health legislation. Along the continuum, Patient Advocates provide formal and informal education for health and social service practitioners, community-based agencies, and students in the health sciences and legal profession.

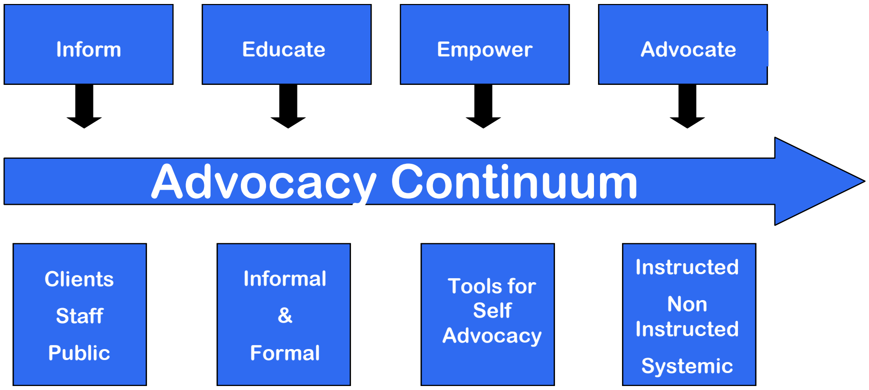


Figure 1: The Advocacy Continuum

At a more advanced level, Patient Advocates assist patients to self-advocate the issues that they have brought forward to the Advocate for resolution. The Advocate assesses and clarifies the issue with the client and explains options available and assists the client in his or her choice of option(s) and supports the client to follow through with the necessary actions to try to resolve his/her concerns. And finally, the Patient Advocate conducts advocacy activities for the client (individual advocacy) or for a group of clients (systemic advocacy).

Instructed advocacy

Instructed advocacy is a process that incorporates the basic principles of self-determination and client empowerment. As such, it routinely follows client direction and involves the client in decision-making. The PPAO does not substitute a "best interest" approach to resolving the client's concerns. Consistent with PPAO practice, instructed advocacy seeks to resolve issues at the level of least contest and utilizes an approach which emphasizes problem solving. Advocates routinely attempt to discern the concern, context and situation in which a client complaint arose, as well as the outcome the client wishes to achieve. Advocates inform the client about the scope and limits of their role, options that are available and the possible consequences to the client of exercising available options.

When Patient Advocates are presented with advocacy issues, they assess the issue with the client and determine the best strategy for resolution. They take into consideration: the nature and complexity of the issue; the client's ability to self-advocate; information about the client's attempts to resolve the issue; the special needs of the client; barriers to access; and the nature of the client's instructions. Once this assessment is completed, Patient Advocates work with their clients to find a win-win approach to resolve the issue as expeditiously as possible.

> **"Emerging research supports the notion that choice is an important resource for recovery"**

Non-instructed advocacy

Non-instructed advocacy is carried out in situations where a client is unable to provide instruction. The threshold for being able to provide instruction is low and most clients are able to instruct the Patient Advocate. In a small percentage of situations, the Patient Advocate may intervene on behalf of a client where a rights abridgement or quality of life or care issue is identified and the client is unable to provide an instruction. The Advocate's action, according to the PPAO's non-instructed policy and procedure, is limited to making attempts to redress an abridgment of a legal right or therapeutic or social entitlement that imperils the incapable client's health, estate, personal security or human dignity. The Patient Advocate will apprise the client of the progress of the issue and, wherever possible, attempt to elicit instructions.

Systemic Advocacy

In addition to individual patient advocacy issues, the PPAO also addresses systemic issues, which have an impact on the quality of care, life and rights of a large number of patients either local to a facility, or across several or all of the ten tertiary care psychiatric hospitals. Systemic advocacy is also aimed at promoting change in the way the mental health system delivers services to the people it is intended to benefit. By its nature, systemic advocacy can resolve problems more efficiently than the individual advocacy approach by targeting circumstances that affect patients in general. Systemic advocacy can focus on such areas as law, policy reform and consumer empowerment; it may also address practices which hinder the appropriate care of patients and which, if left unchecked, may violate patient rights and entitlements.

Public Education and Community Engagement

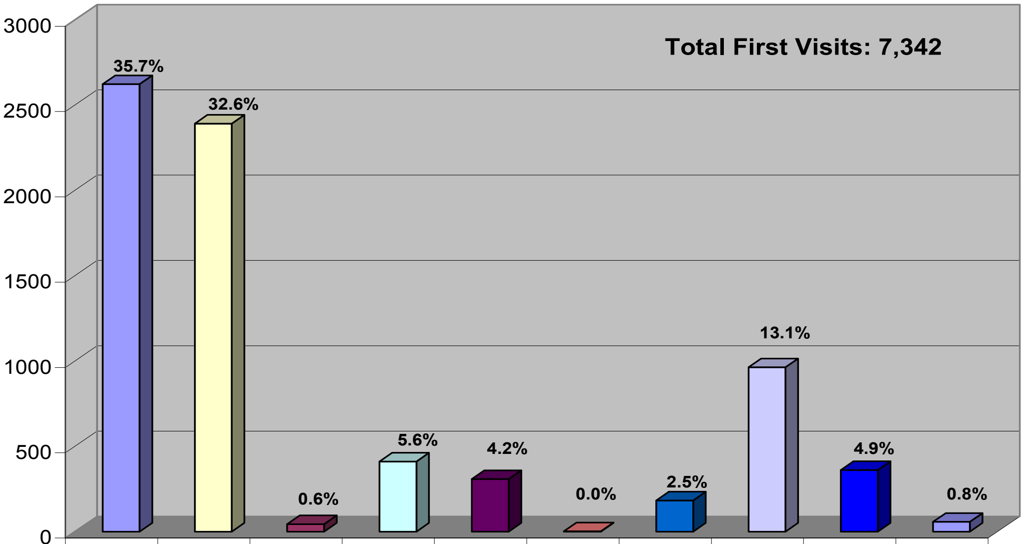
Emerging research supports the notion that choice is an important resource for recovery. Without education and information about basic human and civil rights, patients' rights under mental health legislation, stigma, criminalization and victimization of persons with mental illness, how could recovery occur?

Every day PPAO staff members provide information to clients to assist them to make choices. Our approach to advocacy proceeds from informing individuals about their rights and options, and then providing support and assistance to achieve the clients' defined goal. Indeed, providing information about legal and civil rights to patients, families, hospital staff and the broader community has been a cornerstone of the PPAO's mandate since 1983. Education of this nature supports the replacement of myths about mental illness with accurate conceptions with an intention to reduce stigma, and contribute toward changing attitudes that are barriers to recovery.

With the development of the Internet, information about patient rights has been disseminated far and wide. In addition to the PPAO's direct educational efforts, our website offers a comprehensive menu of our work.

Rights Advice in Tertiary Care Psychiatric Facilities

In 2010, as seen in Figure 2, there were 7,342 initial visits for rights advice in the tertiary care psychiatric facilities. Of the total number of visits, 68.3% were for involuntary admission (Form 3 and 4), 13.1% concerned incapacity to consent to treatment (Form 33t), 9.8% were for financial incapacity (Forms 21 and 24), and 4.9% and 0.8% for the issuance (Form 49i) and renewal (Form 49r) of CTOs , respectively, while 2.5% of the visits concerned incapacity to consent to the collection, use or disclosure of personal health information (Form 33PHI). A very small percentage (0.0%) concerned visits regarding admission as an informal patient (Form 27).



	Form 3	Form 4	4th Renewal	Form 21	Form 24	Form 27	Form 33PHI	Form 33t	Form 49i	Form 49r
Forms Issued	2623	2392	44	411	307	2	182	963	361	57

Figure 2: Rights Advice Activity in Tertiary Care Psychiatric Facilities

MHA Form	Explanation	CCB Application
Form 3:	person made an involuntary patient	Form 16
Form 4:	person's involuntary status continued	Form 16
4th Renewal Form 4:	Fourth renewal of involuntary status	Form 19
Form 21:	person is found incapable to manage property	Form 18
Form 24:	person’s incapacity to property is continued	Form 18
Form 27:	person is a 12 to 15 year old informal patient	Form 25
Form 33PHI:	incapable to consent to collection, use & disclosure of personal health information	Form P-1 P-3
Form 33t:	patient is found incapable to consent to treatment	Form A
Form 49i:	intention to issue a community treatment order	Form 48
Form 49r:	intention to renew a community treatment order	Form 48

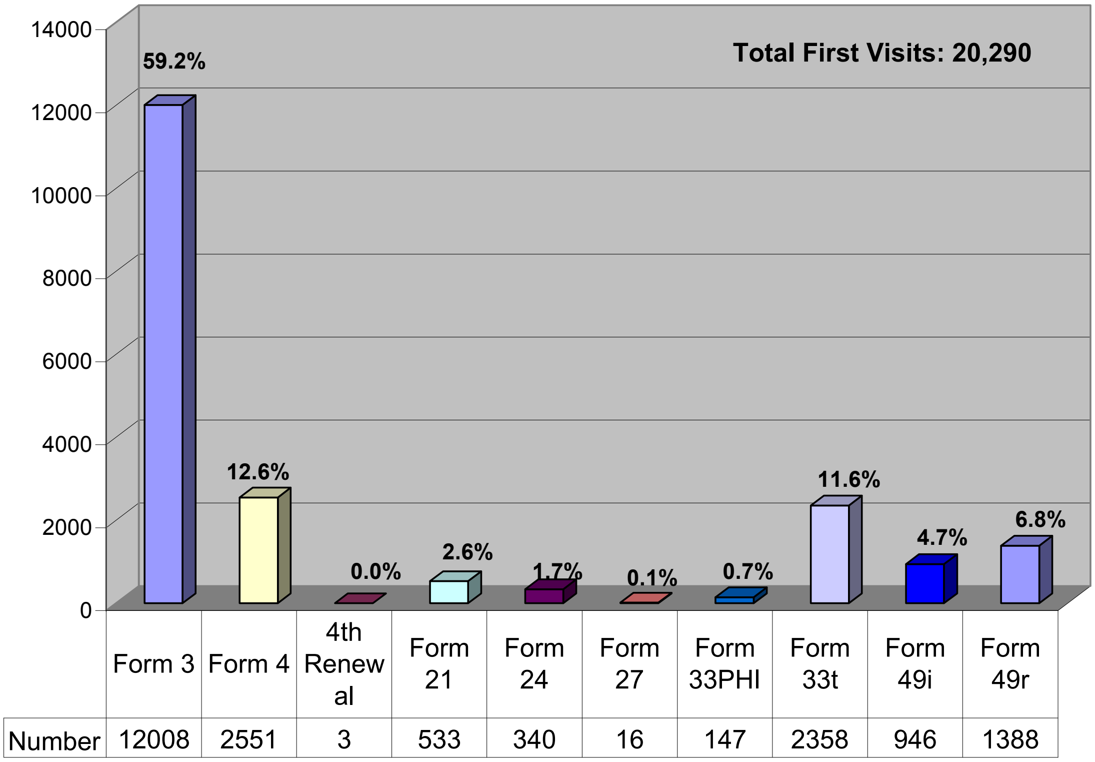
Table 1: Key to Forms Issued and CCB Applications Made

Rights Advice

Community-Based Rights Advice

Pursuant to a change in the Regulations to the *Mental Health Act (MHA)* in December 2000, general and specialty hospitals had the option of providing rights advice themselves or designating the PPAO to provide the service. Amendments to the *MHA*, as well, extended the provision of right advice to persons living in the community and being considered for a CTO and their substitute decision-maker, if any. The PPAO began its community-based rights advice program to provide this new service on June 18, 2001 to those hospitals that chose to designate the PPAO as service provider.

As shown in Figure 3, the PPAO responded to requests to visit clients regarding 20,290 forms in the mandatory rights advice situations under the *MHA*. The majority of the forms were regarding involuntary admission (71.8%); this included both certificates of involuntary admission (Form 3) (59.2%) and renewals of certificates of involuntary admission (Form 4) (12.6%). Rights advice for treatment incapacity (Form 33t) comprised 11.6% of the forms, while incapacity to manage property (Form 21 and 24) accounted for 4.3%. Clients admitted as informal patients (Form 27) represented 0.1% of the forms.



	Form 3	Form 4	4th Renewal	Form 21	Form 24	Form 27	Form 33PHI	Form 33t	Form 49i	Form 49r
Number	12008	2551	3	533	340	16	147	2358	946	1388

Figure 3: Community-based Rights Advice Activity Totals for 2010

The intention to issue a CTO (Form 49i) and to renew a CTO (Form 49r) represented 4.7% and 6.8% of the forms, respectively. Findings of incapacity to collect, use or disclose personal health information (Form 33PHI) represented 0.7% of the forms. Most of the CTO renewals and associated rights advice visits were for individuals who were in the community.

Where completion of rights advice delivery was not possible at the first visit for reasons outside the control of the Rights Adviser, second rights advice visits were made in 2,408cases.

Language Accommodation

Clients come from diverse cultural and linguistic backgrounds, and some required interpretation in their own languages. Accordingly, rights advice was provided with interpretation in 46 languages in 430 cases.

Figure 4 shows the diverse languages in which rights advice was provided through the use of language interpreters (expressed as a percentage). Table 2 is a list of the interpreted languages that are included in "Other".

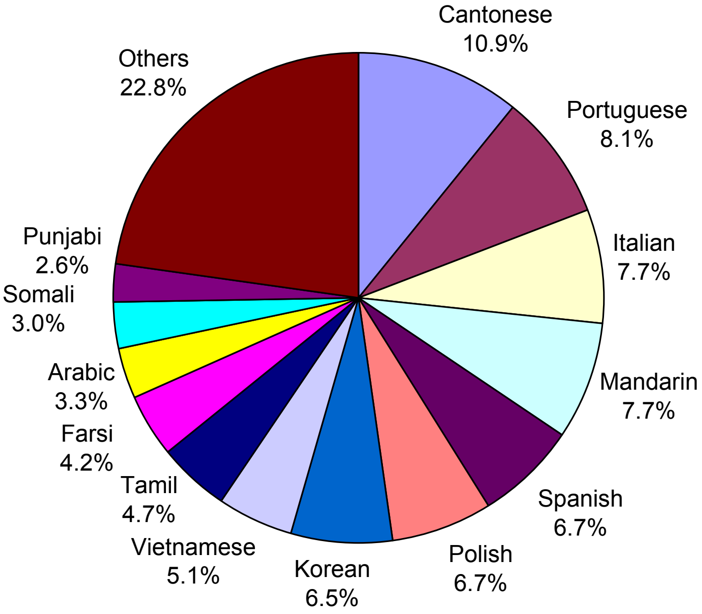


Figure 4: Languages in which Rights Advice was Provided by Use of Interpreters, Community Based Rights Advice Program

Albanian	Ellogano	Portuguese (Brazilian)
Amharic	French	Romanian
Arabi Juba	Fukian	Russian
Armenian	Greek	SEE-Signing Exact English
ASL Sign Language	Hindi	Serbian
Bosnian	Hungarian	Sudanese
Bulgarian	Kinyarwanda	Tagalog
Cambodian	Macedonian	Toisan
Croatian	Ojibway	Turkish
Czech	Pashto (Afghani)	Ukranian
Dari (Afghani)	Persian	Urdu

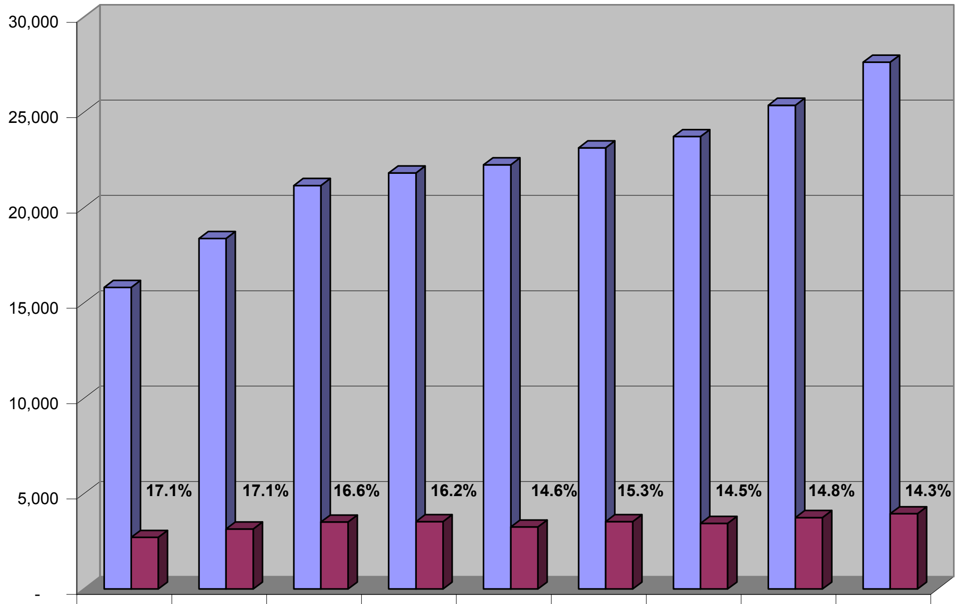
Table 2: Languages included under "Other" in Figure 3 Community Based Rights Advice Program

Rights Advice

Applications to the Consent and Capacity Board

The Consent and Capacity Board (CCB) is an independent provincial tribunal that conducts hearings under the *Mental Health Act*, the *Health Care Consent Act*, the *Personal Health Information Protection Act*, the *Substitute Decisions Act* and the *Mandatory Blood Testing Act.* The CCB adjudicates matters regarding treatment capacity and capacity to manage property, involuntary admission to hospital, capacity to consent to the collection, use and disclosure of personal health information and substitute decision-making.

Across all psychiatric facilities and the community, the percentage of applications to the CCB has been relatively consistent over the past nine years (Figure 5). In 2010 there were 1,233 applications to the CCB with respect to forms issued in the tertiary care psychiatric facilities and 2,722 applications to the CCB with respect to forms issued in the other Schedule 1 psychiatric facilities and in the community. There is a marginal downward trend in the percentage of applications to CCB, with applications ranging from 17.1% in 2002 to 14.3% in 2010.



	2002	2003	2004	2005	2006	2007	2008	2009	2010
■ Total Forms	15,817	18,381	21,164	21,822	22,255	23,138	23,736	25,376	27,632
■ CCB Applications	2,711	3,147	3,518	3,534	3,258	3,535	3,441	3,751	3,955

Figure 5: Consent and Capacity Board Applications, 2002-2010

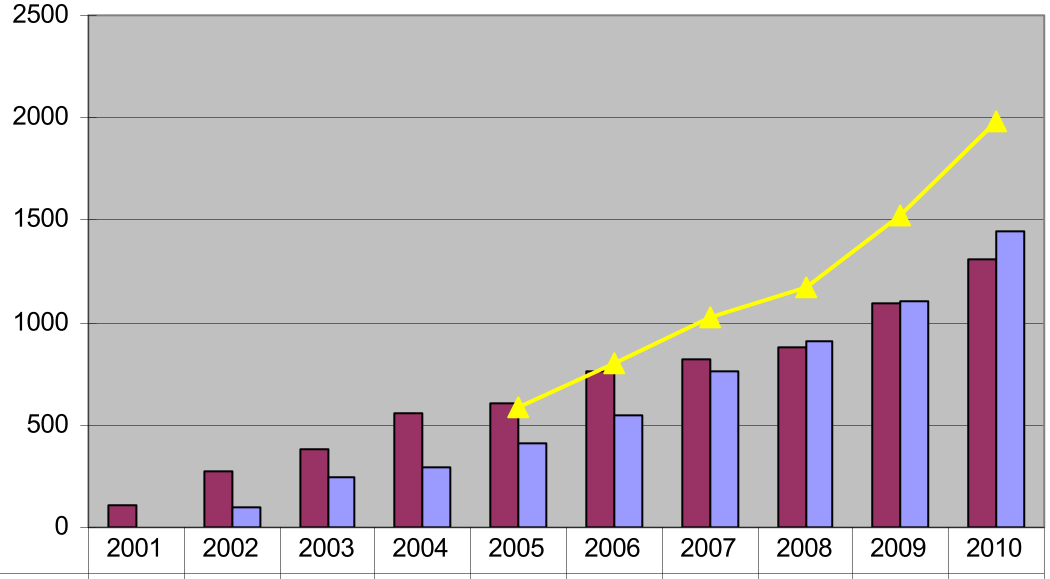
Rights Advice for Community Treatment Orders

In 2010, there were 2,753 total requests for rights advice on an intention to issue or renew a Community Treatment Order (CTO) (Form 49) across all tertiary care psychiatric facilities and in the community. 1,309 (47.5%) requests were received for issuances, while 1,444 (52.5) were for renewals. (Figure 5) Compared with 2009, there was a 19.9% increase in the number of issuances and a 30.5% increase with respect to renewals.

Since the inception of CTOs in mid-2001, there has been a steady increase in the provision of rights advice—in excess of a 7-fold increase from 2002 (365) to 2010 (2,753) for intentions both to issue and renew CTOs. In 2010 renewals continued to outnumber issuances. Not every individual continues on a CTO, and sometimes physicians pass the allowed renewal period and have to re-issue a CTO, instead of renewing it.

There are not only more individuals on CTOs, but a greater proportion of these individuals were found incapable of consenting to the issuance or renewal of a CTO. Accordingly, a greater percentage of issuances and renewals were consented to by substitute decision-makers (SDMs) with an overall rise in rights advice given to SDMs from 57.6% in 2005 to 71.9 in 2010.

The number of capable people consenting to their own CTOs raises questions about how CTOs are being used and in particular, whether they are used as a way to access supports and services otherwise unavailable in the community. The underlying assumption here is that a CTO must offer considerable benefit to the capable individual to encourage entering a potentially restrictive agreement that must be adhered to.



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
🟥 Issue	105	269	377	553	604	763	819	875	1092	1309
🟦 Renew	3	96	242	292	412	548	764	911	1106	1444
▲ SDMs					585	802	1024	1169	1526	1980
Total I+R	108	365	619	845	1016	1311	1583	1786	2198	2753

Figure 6: Requests for Rights Advice received on intention to issue or renew a CTO from 2001 to 2010

Community Based Rights Advice

Ongoing Case Law

During the year the PPAO became aware of two situations in which clients had had their applications for hearing on CTO treatment incapacity turned down. The reason given by the CCB was that they agreed with the doctor's contention that a hearing for CTO treatment incapacity was not sufficiently a "material change in circumstances" to warrant a hearing. In earlier hearings, the CCB had ruled that the fact of a CTO constituted a material change in circumstances. PPAO's legal counsel and the Program Manager have raised the issue with the CCB.

Best Efforts Rights Advice

When a person living in the community is subject to the issuance or renewal of a CTO, it is sometimes difficult, despite the best efforts of a rights adviser, to contact a client to offer rights advice. Clients frequently lead complicated lives – perhaps they have no phone or in some situations no fixed address.

In 2010 the passage of Bill 16 *Creating the Foundation for Jobs and Growth Act, 2010* brought changes to the *MHA*, including a clause whereby a rights adviser may issue a "best efforts" Form 50. Best efforts must include, but are not limited to making multiple attempts to contact the client, at different times of day and in different ways. Contact with the CTO Coordinator is required, to see if there might be another way of contacting the client. Contact attempts are tracked by the PPAO and are submitted to a supervisor before the Form 50 can be issued. A letter is subsequently sent to the client to invite them to contact the PPAO to receive rights advice.

However, in its submission to the Standing Committee on Finance and Economic Affairs the PPAO noted:

"the inability to locate a client may indicate a deeper problem with the CTO. It calls into question the stability of the situation into which the client is being placed and the adequacy of the support services being offered to them as they resume living in the community. As the purpose of CTOs is, in part, to stop the "revolving door" of readmission through stabilized community arrangements, it should be of concern that the purpose has become frustrated before the CTO has even been issued."

Instruction Based Rights Advice

A fundamental tenet of rights advice is that it be "instruction based" and not "best interests". In a recovery model of mental illness, vesting decision making powers with the client is central. The PPAO provides for each form:

- The change in legal status
- The implications of the change in legal status
- The action alternatives available to the client
- Facilitation of the client's choice of action(s)
- Accommodation based on the client's needs and expressed wishes

For example, as a consequence of his beliefs, a client was reluctant to sign the application forms for the CCB and Legal aid. Nevertheless the client wanted to apply. To accommodate their concerns and follow instructions, the Rights Adviser completed the forms and signed them "verbal consent given", then forwarded them to the appropriate agencies.

Professional Development

The provisions of the *Creating the Foundation for Jobs and Growth Act, 2010* **(**Bill 16) came into force immediately upon passage of the bill, requiring significant change to rights advice policies and procedures. To that end, Head Office prepared a memo for all Rights Advisers covering

- what the provisions of the new Act were that affected rights advice,
- the changes to relevant forms and how rights advisers were to complete them, and
- the concrete changes in the provision of rights advice.

Within Schedules 9 and 18 of the bill are amendments to the *MHA* creating a new form of rights advice for involuntary transfer applications and modifying some aspects of community treatment orders. Changes were made to Form 50 and Form 30, and a new Form 19 has been introduced for involuntary transfer applications.

Tertiary Care Psychiatric Facilities Rights Advice

Client's release from hospital supported following revocation of Certificate of Involuntary Admission by the Consent and Capacity Board

The Rights Adviser provided rights advice to a client that was being detained on a Certificate of Involuntary Admission or Form 3. The client was assisted by the Rights Adviser in applying to the CCB for a review of his involuntary status. Legal counsel was retained on the client's instructions. The client was successful at his hearing before the CCB and the Certificate of Involuntary Admission was revoked. Though members of the clinical staff were aware of the CCB's decision, they refused to release the client, asserting that the client must first meet with his doctor before he could be released. At the client's request, the Rights Adviser contacted the client's lawyer. The lawyer came to the hospital without delay and escorted the client home.

Client supported in making an informed decision about a Community Treatment Plan and the issuance of a Community Treatment Order

The Rights Adviser received notice to provide rights advice on the issuance of a CTO. The client who was subject to the proposed CTO was capable of consenting to treatment under the *Health Care Consent Act*. In reviewing the Community Treatment Plan (CTP), in preparation for providing rights advice, the inclusion of a condition unrelated to treatment was noted. Namely, the client was expected to comply with employment counselling. This inclusion was flagged by the Rights Adviser who requested a legal opinion from legal counsel for the (PPAO). PPAO Legal Counsel recommended bringing the issue to the attention of the CTO coordinator to consider a change to the CTP on discussion with the client and his psychiatrist. The CTO coordinator declined to review and potentially amend the CTP at the request of the client. Rights advice was provided to the client as required by law. In addition, the client had identified concerns regarding the medication regimen proposed in the CTP. The client was provided with rights advice and information on what he could do to address the concerns he had about the CTP. The client was willing to consider consenting to the CTP if changes could be made to the proposed medication regimen. The client did not wish to consent to the CTP and the issuance of a CTO following discussion with the CTO coordinator. The client was subsequently discharged without a CTO.

Client on medical unit questions involuntary detention under the Mental Health Act

Rights advice was provided to a non-psychiatric client on a medical floor who had been placed on a Certificate of Involuntary Admission (Form 3). The client told the Rights Adviser that she had been assessed by a psychiatrist who told her she needed to be detained under the *MHA*. The client asserted that she did not have a mental illness and that she believed she was inappropriately detained by the psychiatrist who assessed her; she indicated that she was distressed because her husband was critically ill and thought this was misperceived by hospital staff. The client asked for a second visit by the Rights Adviser to consider her options, should she be unable to convince the doctor to rescind her involuntary status. The client requested assistance from the Rights Adviser in applying to the CCB to review her involuntary status, since the doctor declined to meet with her in a timely manner. The doctor cancelled the client's involuntary status two days following her application to the CCB. The client believed the assistance of the Rights Adviser was instrumental in protecting her voluntary status in hospital.

Substitute decision-maker declines to support Community Treatment Plan and Issuance of a Community Treatment Order

While rights advice must be provided as mandated on the intent to issue or renew a CTO despite any concerns regarding the content of the CTP, there may be times when this process is sufficiently flawed to pose a barrier to the provision of rights advice. A Rights Adviser had received notice to provide rights advice to a client's substitute decision-maker (SDM) on the intent to issue a CTO. In the course of rights advice, the SDM disclosed to the Rights Adviser that she had not consented to the CTP and did not wish to be the client's SDM. She indicated further that she had not had a discussion with the client's doctor regarding the proposed CTP and her role as SDM; she had only been told by hospital that she was the client's SDM. On discussion with the PPAO's Program Manager and Legal Counsel, it was decided that since the individual identified as the SDM had declined to assume this role, there was no SDM to provide rights advice to. The Rights Adviser notified the CTO coordinator who subsequently contacted the doctor who was proposing the CTO. The client's psychiatric abandoned the issuance of the CTO based on the identified SDM's unwillingness to consent to the CTP and issuance of a CTO.

Individual Advocacy

Files Opened

In 2009, the PPAO opened 2,889 files. Files generally correspond to individual clients, with some clients raising multiple issues. Figure 7 captures the total number of files opened, broken down by patient status under the *MHA*. Of the files opened in 2009, 53.2% were opened for clients detained under the *Criminal Code* (the *Code*) and 26.0% for clients who were held involuntarily under the *MHA*. In contrast, clients admitted as voluntary patients comprised 10.6 % of the files. A small percentage, 1.0%, of patients seeking advocacy services had dual status, i.e. held under authority of both the *Code* and *MHA*, while 0.1% were admitted as informal child and adult patients.

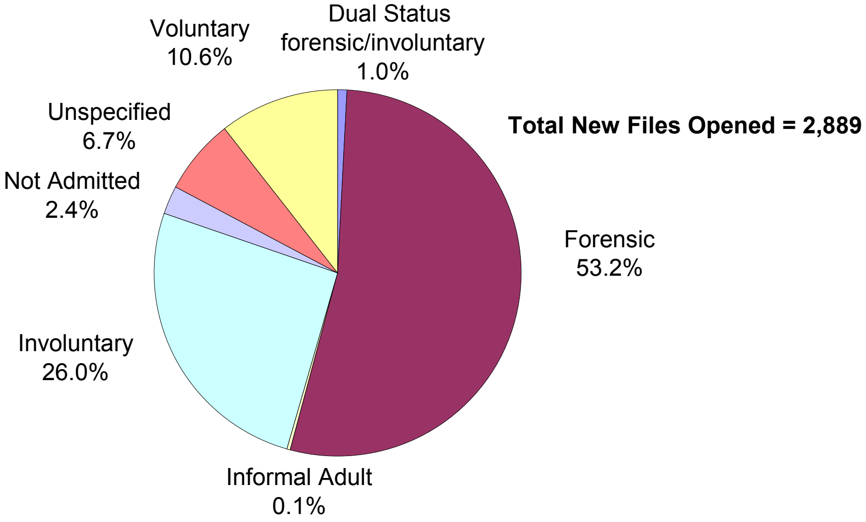


Figure 7: Files Opened by Patient Status

Client Profile

Table 3 provides the age and sex profile of those receiving advocacy services. Men represented the majority of clients served (70.%). Women comprised 25.% of clients. The majority of clients fell between the ages of 25-54 (45.2%), while a small percentage of clients was either under the age of 24 (4.4%) or 65 years of age or over(4.5%).

Age Group	**Sex**			**Group Total**	
	Male	Female	Unknown	Total	%
0-14	0	0	0	0	0
15-24	97	28	2	127	4.4
25-34	405	82	14	501	17.3
35-44	359	66	0	425	14.7
45-54	263	118	1	382	13.2
55-64	292	105	0	397	13.7
65+	99	30	0	129	4.5
unspecified	508	293	127	928	32.1
Total	2023	722	144	2889	100
Percent	70	25	5	100	

Table 3: Files Opened by Age Group and Sex

Referral Source

As captured in Figure 8, clients sought advocacy services on their own behalf in 28.8% of the cases. Hospital staff referred clients to Patient Advocates for service 7.1% of the time. Other sources and family and friends accounted for 2.1% and 0.8% of the referrals, respectively. Referral sources were not specified in 53.3% of the cases. PPAO staff themselves made referrals in 3.6% of the cases.

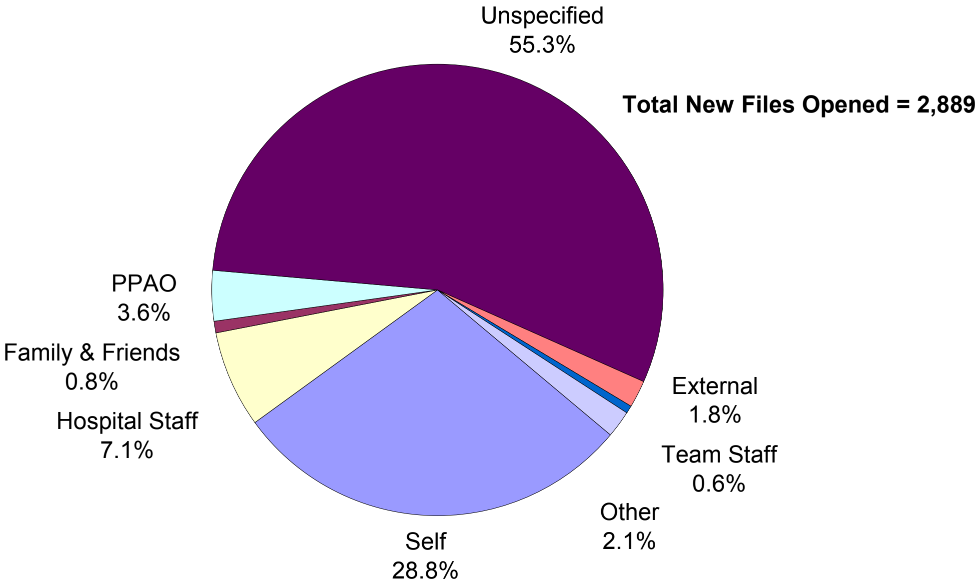
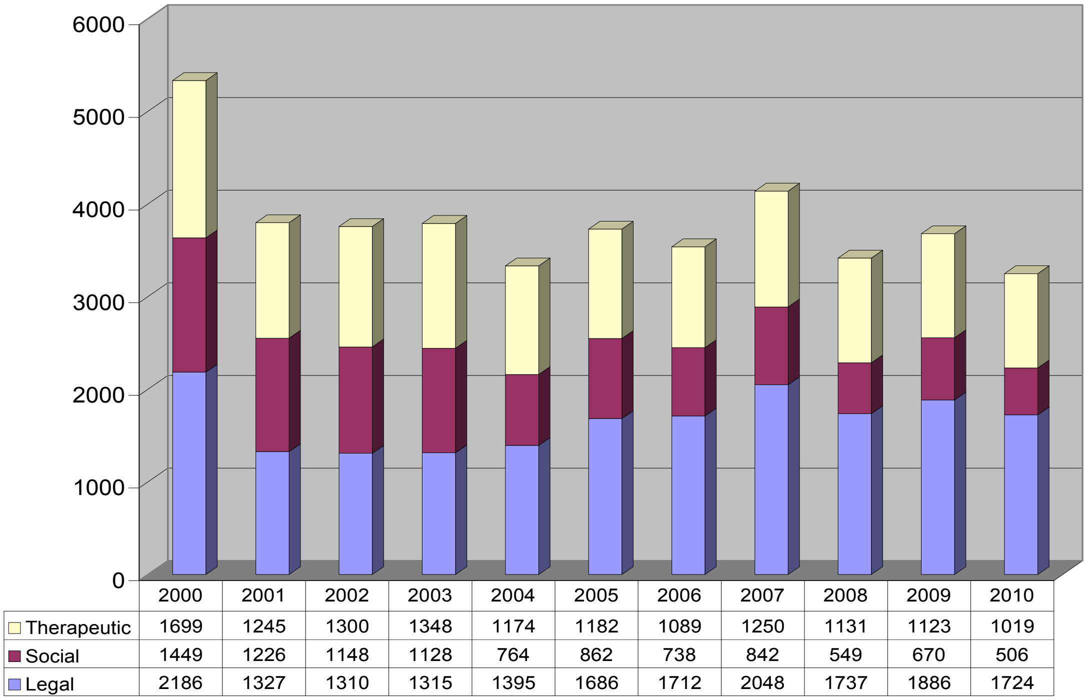


Figure 8: Files Opened by Source of Referral

Individual Advocacy

Advocacy Issues

Figure 9 compares the total individual advocacy issues that were addressed from 2000 through 2009. In 2009, Patient Advocates, across all ten tertiary care psychiatric facilities, addressed 3,659 issues resulting in 8,836 actions (Figure 10) on behalf of or with clients, up from 8,627 actions in 2008. Therapeutic issues comprised 30.7% of the total issues addressed (Figure 8), while social and legal issues represented 18.3% and 51% of the total issues, respectively.



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
☐ Therapeutic	1699	1245	1300	1348	1174	1182	1089	1250	1131	1123	1019
■ Social	1449	1226	1148	1128	764	862	738	842	549	670	506
■ Legal	2186	1327	1310	1315	1395	1686	1712	2048	1737	1886	1724

Figure 9: Advocacy Issues Addressed 2000—2010

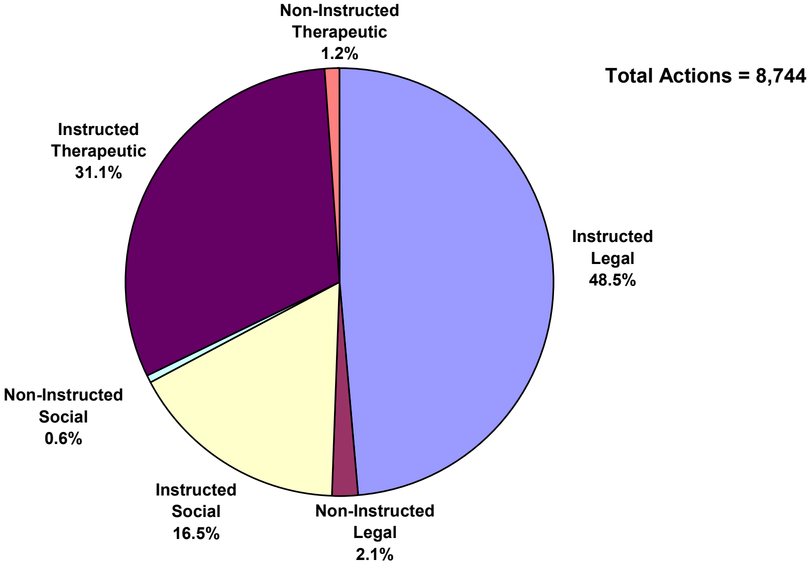


Figure 10: Patient Advocate Actions 2010–Instructed and Non-Instructed

Advocacy Interventions

Figure 11 shows the breakdown of Patient Advocate interventions used to resolve client issues. Advocates across all field offices carried out 8,744 actions in addressing client concerns.

Resolution was sought through consultation (18%); discussion of options (17%); providing information (23%); providing assistance (13%); negotiation (4%); referral (3%); arranging meetings (2%); investigation (2%); drafting written materials (3%) and assisting clients to complete forms (5%); and other, situation-specific strategies (9%) as necessary (see Table 4 below).

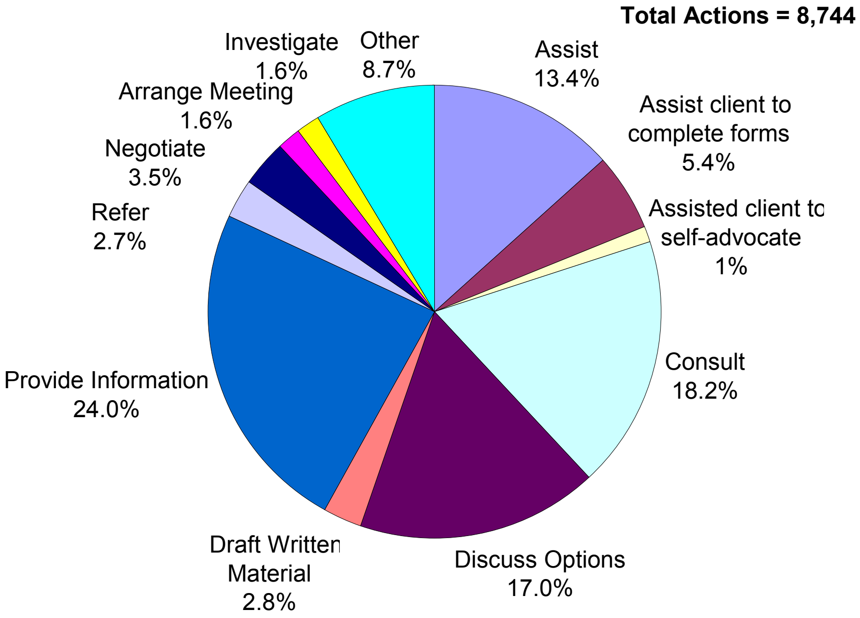


Figure 11: Patient Advocate Actions

Other Actions	%
Assist client to file appeal	0.4
Attend case conference/team meeting	0.5
Attend Court	0.03
Attend Ontario Review Board Hearing	0.03
Collaborate	0.4
Escalate Issue	0.5
Lobby	0.01
No action required	0.5
Other – specify in Comments Box	3.4
Research/Investigate	1.1
Review Clinical Record	1.1
Support client to self-advocate	0.9
Total	8.7

Table 4: Actions Covered in "Other" in Figure 11

Individual Advocacy

Forensic client assisted in obtaining legal representation despite denial of legal aid

A forensic client who had been denied legal aid was referred to the Patent Advocate for assistance in obtaining legal support. The client had already spent time in jail and refused legal aid because "jail was not likely." Client did not know when he had received a letter from Legal Aid Ontario (LAO) advising that he had been denied legal aid. Client did not believe he was facing criminal charges and thought he was going to court to get his motorcycle back which was stolen several years before.

The client's belief posed a communication challenge but the Patient Advocate was able to obtain the client's instruction after several conversations, which helped the client to understand that he needed a lawyer. He instructed the Patient Advocate to assist him in appealing his denial of legal aid. Legal Aid verified that the denial of the client's application was based on the determination that a jail sentence was an unlikely outcome. After frustrated attempts to informally address the client's denial of legal aid and on instruction by the client, the Patient Advocate formally appealed LAO's decision.

The Patient Advocate provided an appeal letter to LAO explaining: the client's circumstances; stating advocate's opinion that client did not fully understand the legal proceedings, including the nature of the charge, and therefore required legal counsel and setting out the circumstances as to the delay in submitting the appeal. Since client's court date was imminent, the Patient Advocate contacted the Duty Counsel in Mental Health Court, who advised that she would check in advance about the outcome of the LAO appeal and represent the client, if needed, on his return to court.

Though the appeal was denied because it was submitted after the limitation period, the Patient Advocate was able to escalate this matter as a systemic issue to the Area Director of LAO, who advised that late appeals, with reasons for the delay, should be flagged and that they would be considered in the future on a case-by-case basis.

> **"The resolution of this issue spanned two years and required the ongoing and active support of the Patient Advocate"**

Client assisted in limiting unwanted home visits by parents

An adult client with complex mental health needs and a history of childhood abuse by her parents requested the assistance of the Patient Advocate in obtaining a no trespass order against them. Past attempts by clinical staff to obtain a restraining order on behalf of the client were unsuccessful. The client instructed the Patient Advocate to call police to seek ideas about legal means to prevent parents from seeing her. The Patient Advocate contacted the police and other parties and organizations to explore options in support of the client's identified outcome; these included: the Sexual Assault Centre, the Crown Attorney, a community housing resource and a previous defence lawyer.

Defence counsel thought a peace bond should be obtained by the facility on the client's behalf on the basis of her file with client as a secondary witness given her intellectual challenges and trauma.

Following the client's discharge from hospital to a group home, her parents began attempting visits without her consent and she became very fearful. Group home staff were unwilling to call police and management would not seek a no trespass order. The client needed to be readmitted to the hospital due to the stress engendered by her inability to find a viable means to prevent parental visits to her group home. The Patient Advocate persisted in exploring a number of approaches to obtaining a restraining order, enlisting the support of the Public Guardian and Trustee (PGT) and the police. Before this process could be completed, the client was referred to a group home in location that was far away from the parents' home and not accessible by public transit. The client's referral to a group home that was inaccessible to her parents supported the client's identified outcome, which was to have no further contact with her parents.

The resolution of this issue spanned two years and required the ongoing and active support of the Patient Advocate.

Client supported in addressing concerns regarding the interpretation and application of an Ontario Review Board disposition

The Ontario Review Board (ORB) has the duty to create disposition orders that are the least onerous and least restrictive for forensic clients, striking a balance between individual treatment and rehabilitation needs and the safety of the public. Often, little guidance is provided by the ORB regarding the application and implementation of its dispositions. This leaves considerable room for interpretation by clinical teams. Many forensic clients take issue with the way in which their dispositions are interpreted and implemented.

The Patient Advocate assisted a client whose disposition stated that she cannot disseminate any material of a particular nature. She shared with the Advocate that, at times, she felt more comfortable communicating in writing and therefore wrote a letter to her psychiatrist about her concerns. Her psychiatrist refused to read the letter until it was reviewed by staff and redrafted by the client, if necessary, as it may contain material contrary to the disposition. This created an added barrier between the client and her treating psychiatrist, leaving her feeling that she was unable to communicate with him. Could the ORB have meant that the client could not share feelings/positions connected to the index offence with her treating psychiatrist? Upon client instruction, the Patient Advocate escalated this concern to clinical and administrative leadership of the Program and the issue was soon resolved; but this example highlights the type of barrier forensic clients may face when clinical staff are left to interpret ORB dispositions.

Shortfalls in discharge planning process remedied

A client contacted the PPAO after he had been discharged with no place to stay and no outpatient or other clinical follow up. After escalation of the issue, the Patient Advocate was advised by the clinical director of the program that the discharging psychiatrist would follow the client on an outpatient basis, if the client wished. Approximately three weeks later, the client called the Advocate expressing desperation because he had been working very hard to secure housing and continue on his path to recovery; however, despite his best efforts, he had been unable to find a community psychiatrist. He stated that when he was initially discharged from the facility, he had decided not to seek outpatient support because he felt unsupported by the psychiatrist, and had not anticipated the difficulty he now encountered in finding a community psychiatrist.

Finding himself in need of a renewal for his prescriptions and assistance in finding outpatient support, he contacted his inpatient psychiatrist, who declined to meet with him and/or refill his prescriptions. When contacted by the Patient Advocate, the inpatient psychiatrist took the position that since the client had declined his help earlier, he was not willing to work with the client now, following his discharge. No suggestion or referral was provided by the client's doctor.

The Patient Advocate again escalated the issue to the program's clinical director who conceded that there was confusion regarding what support was offered to the client. The Advocate gave voice to the client's experience and this resulted in his being referred to the hospital's short term crisis support program, which could offer him assessment, prescription renewal and linkage to outpatient supports.

Release from locked seclusion hastened by advocate's intervention

The Patient Advocate met with a client who was in locked seclusion. The client was initially made aware of why he was placed in seclusion approximately nine hours earlier; but was unsure why he remained there. The Patient Advocate provided the client with information on his rights regarding restraint under hospital policy. Upon client instruction, the Patient Advocate facilitated a meeting between the client and his assigned nurse. Empowered by the information and supported by the Advocate, the client was able to learn why he was still in restraint.

With this information, the client was able to engage in a discussion with his nurse around his actions and intent. At the end of this discussion, the client was offered a trial out of seclusion. Shortly afterwards, the Patient Advocate confirmed that the seclusion order was discontinued. The client subsequently told the Advocate that he felt her intervention hastened his release from seclusion and helped him formulate a plan to prevent future events.

Voluntary patient's right to not be detained upheld

A client contacted Patient Advocate by phone to complain that he has not being able to leave the unit even though he was a voluntary patient. The client told the advocate that despite repeated request to leave the unit to go outside and smoke he was detained on a locked unit. He instructed the Patient Advocate to speak to his nurse or psychiatrist so he could leave the unit.

The Advocate confirmed the client's voluntary status and contacted nursing staff and informed her of the client's wish to leave the unit. The Patient Advocate reminded nursing staff of the client's status as a voluntary patient and his right under the *MHA* not to be detained. Staff confirmed there were no current concerns to warrant a determination of whether the client met criteria under the *MHA* for involuntary admission. Accordingly, the client would be allowed to leave the unit as requested.

Systemic Advocacy

Systemic advocacy is a process that often requires action at a variety of levels within health and social service systems of care, treatment and support, the courts and government in order to effect positive change. This process requires diligence and perseverance over a long period, as lasting progress seldom happens overnight. Promoting rights is about catalyzing social change. It is about slowly and incrementally raising awareness, reducing barriers to accessing existing rights and justice, eliminating discrimination and enshrining in law recognized standards of protection for individuals with mental illness and disability.

The following examples capture the PPAO's efforts to advocate for social change through provincial action. Some of these issues require continued advocacy and are representative of the work carried out by PPAO staff and other stakeholders, over an extended period of time.

Submission regarding Bill 16, Creating the Foundation for Jobs and Growth Act, 2010

The Legislature introduced a variety of amendments through *Bill 16, Schedules 9 and 18,* amending the *Health Care Consent Act* and the *Mental Health Act*. The PPAO was among the few groups given the opportunity to directly address the Legislative Committee on Finance and Economic Affairs with recommendations for improving the Bill. Many PPAO recommendations were incorporated into the legislation, including the continued provision of rights advice to substitute decision-makers. In response to the legislation, the PPAO also developed a "best efforts" policy for providing rights advice on a Community Treatment Order. This policy ensures that client rights are fully respected throughout the process.

Police Record Check Coalition supports the development of a new guideline for police record checks

In 2010, the Police Record Check Coalition, which is co-chaired by the PPAO, began working directly with the Ontario Association of Chiefs of Police (OACP) and the Ontario Human Rights Commission to develop a new *Guideline for Police Record Checks*. For the first time in Ontario, this Guideline provides a single province-wide policy that not only removes any mention of mental health related information from any police record check, but also prohibits the release of any information gathered during contact with a person having mental health needs. This Guideline should significantly reduce incidents of mental health discrimination in employment hiring, volunteer placement, and professional practicum placement in Ontario. The Guideline also includes an appeal process for those narrow exceptions where information about police contact may be reported (though without any mental health information). With the Guideline being approved by the OACP in July of 2011, the Coalition is optimistic that this will encourage binding provincial legislation over the issue.

Modernizing the PPAO's Rights Adviser training program

The PPAO modernized its rights adviser training program. The revised training program is centered around experience-based learning, and each trainee is paired with a senior Patient Advocate or Rights Adviser who mentors the trainee as they role-play each of the nine rights advice situations. Every hands-on practice is followed by a debrief discussing nuances of mental health law, a client-centered rights approach, practice ethics, PPAO policies and procedures, and human rights accommodation and discrimination. As part of its revised program, the PPAO has developed a new Rights Adviser Training Manual, quick reference materials, and a new Rights Advice Policy and Procedure Manual.

Restraint reduction and minimization in the tertiary care psychiatric facilities

The PPAO continues to advance the reduction and minimization of restraint use through its collaboration with the Centre for Addiction and Mental Health and other tertiary care psychiatric facilities through education and *ex officio* membership on facility-based policy development committees. This systemic initiative was informed and guided by the 2008 coroner's inquest into the death of Jeffrey James, who was a forensic inpatient at the time of his death in 2005. Consistent with the recommendations of the coroner's jury, the PPAO is working toward automatic notification for advocates for every restraint event and is also developing a best practice for advocacy to support clients in restraint.

Public Education and Community Engagement

In 2010, visitors from around the world viewed 3,508,270 pages on our website. Figure 12 and Table 5 compare this year's visits to previous years and show the most popular pages, respectively.

http://www.ppao.gov.on.ca

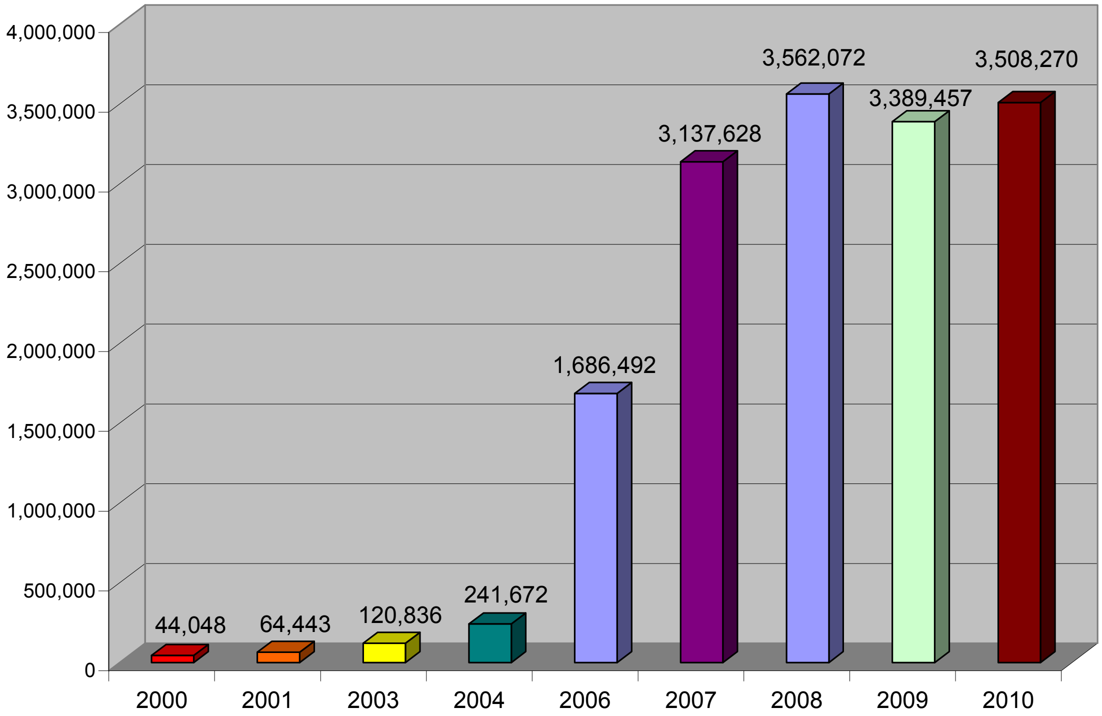


Figure 12: Successful Page Views of PPAO Website, 2000 to 2010

IPC Police Background Check
25th Anniversary Special Report
Police Background Checks IPC John Swaigen
Infoguide: Police Record Checks
James Inquest
20th Anniversary Report
Infoguide: Form 1 Assessment
Infoguide: CTOs
Infoguide: Driver's License Suspension
Infoguide: Human Rights Complaints

Table 5: Ten Most Requested Website Pages

Public Education and Community Engagement

Over the course of the year, PPAO staff members participated in a wide variety of both formal and informal educational events across the province. Formal submissions regarding proposed legislation, letters to the editor, information and rights guides and position papers can be accessed through our website.

Mental Health and Mental Illness Awareness Week activities across the province

- Community Services Fair
  Service Agencies and General Public
  (Frontenac, Lennox and Addington)

Facility Staff Orientation

- RNs and RPNs:
  Rights Advice
  (Brockville)

- RNs:
  Patient Advocate and Rights Adviser
  (Brockville)

- St. Josephs Staff:
  "The Role of the PPAO"
  (Hamilton)

- St. Josephs Security Staff:
  "The Role of the PPAO"
  (Hamilton)

- Ross Memorial Staff
  "The Role of the PPAO"
  (Hamilton)

- London Regional Mental Health Centre
  New Staff Training:
  "The Role of the PPAO"
  (London)

- London Regional Mental Health Centre
  DSW Staff Training:
  "The Role of the PPAO"
  (London)

- The PPAO, Rights and Advocacy
  Canadroe and Nipising Nursing Students
  (North Bay)

- New facility staff:
  Bill 16
  (Penetanguishene)

- Legal Aid Staff
  The Role of the PPAO
  (Penetanguishene)

- Institutional Staff
  Appeal reasons for CCB decisions,
  (Thunder Bay)

- Ontario Shores Mental Health Centre
  (OSMHC) New Clinical Staff:
  The PPAO, Role of the Advocate, Rights
  Advisor; Patient Rights and Entitlements
  (Whitby)

- Forensic Outpatient Team
  Treatment and Financial Incapacity in the
  Community
  (Whitby)

- The Role of the PPAO
  OSMHC Clinical Staff:
  (Whitby)

- 12-15 Year Old Consent and Capacity
  OSMHC Clinical Staff:
  (Whitby)

Presentations to Students

- St. Lawrence College
  Nursing Students
  (Kingston)

- Loyalist College
  Social Service Worker Program
  (Belleville)

- Overview of PPAO, RA and RA
  RPN Students
  (Brockville)

- Mohawk College:
  Nursing Students
  (Hamilton)

- University of Western Ontario:
  Nursing Students
  (London)

- University of Western Ontario:
  Occupational Therapy Students

(London)

- The PPAO, Rights and Advocacy
  Canadroe and Nipising Nursing Students
  (North Bay)

- Patient's Rights and Resolution Process
  St. Joseph's Health Ed Class
  (North Bay)

- Patient Treatment: Advocate Office Functions
  Community Clients, PEP employees
  (North Bay)

- University of Toronto:
  Nursing Students
  (Toronto)

- Humber College:
  Nursing Students
  (Toronto)

- Humber College:
  Social Work Students
  (Toronto)

- University of Toronto Criminology Students
  The Role of the PPAO
  (Whitby)

PPAO Staff Ex-Officio Membership on Local and Regional Committees

Brockville: Internal
Clinical Management Committee
Client Empowerment Council Meetings

Hamilton: Internal
Abuse Education Committee
Peer Support Seclusion/Restraint Committee
Smoking Cessation Committee

Hamilton: External
Community Mental Health Advisory Committee.

Kingston: Internal
Recovery Facilitation Team

Recovery Facilitation Team - Involve, Evolve Working Group

Elections Planning Committee

Emergency Restraint Task Force

Kingston: External
Human Services and Justice Coordination Network

Addictions and Mental Health Coalition

Valedictorian of Life, Peer Support Working Group

London: Internal
Regional Mental Health Care Ethics Education Committee

CMHA National Conference Planning Committee

North Bay: Internal
Organizational Ethics
- quarterly to discuss ethics issues and promotion of ethical practice within the facility

Ethics Case Consultation Committee (Ex-Officio)
- at the request of the Chair when case consultation has been requested

Mental Health Promotion Committee
- monthly to assist in planning for Mental Health Week and Mental Illness Awareness Week activities

Recovery Steering Committee
- Monthly for updates and reports on the 9 Action Committee Teams working on the recovery agenda

Orientation Committee
- Presentations to facility staff on the PPAO and patient rights.

Penetanguishene: Internal
Legal Aid Ontario Advisory Committee on Mental Health
Consultative Committee – Community of

Practice/Community Integration

Public Education and Community Engagement

Thunder Bay: Internal

Non-official internal partnership with the Peer Council and the SJCG-LPH Public Relations Officer for MHAW & MIAW week.

Thunder Bay: External

Thunder Bay Regional Health Sciences Centre (TBRHSC) Mental Health Care Team

- to identify and address opportunities for improving the effectiveness and efficiency of mental health services in keeping with the TBRHSC's mission, vision, values and strategic plan.

Northwestern Region Human Services and Justice Coordinating Committee

- to respond to a recognized need to coordinate resources, service, & plan more effectively for people who are in conflict with the law, or at risk of being in conflict.

Toronto: Internal

Seclusion and Restraints Minimization Committee

- Incident Review & Debriefing Workgroup

Smoke-Free CAMH - Clinical Implementation Sub-Committee

Whitby: Internal

Clinical Ethics Committee

Patient Sexuality Task Force

Restraint Minimization Task force

Staff and Organization

The PPAO provides services in ten regional or local offices across the province and has a head office located in Toronto. The PPAO field offices are currently strategically located in each of the tertiary care psychiatric facilities so that our services are accessible to patients of those facilities. Community-Based Rights Advisers are located in cities or regions in close proximity to the psychiatric units of the community hospitals they serve. PPAO staff are independent from the facilities in which they work.

For more information, contact

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