



Psychiatric Patient Advocate Office

ANNUAL REPORT 1999

PPAO

PSYCHIATRIC PATIENT ADVOCATE OFFICE

VISION

The vision of the Psychiatric Patient Advocate Office (PPAO) is that psychiatric patients in the nine provincial psychiatric hospitals in Ontario and the new Centre for Addiction and Mental Health (formally the Queen Street Mental Health Centre) are treated with dignity and respect, that their legislated rights and entitlements are upheld at all times, and that they are actively involved in decisions affecting their life, care and treatment while they are patients in the psychiatric facility.

MISSION

The PPAO provides independent and confidential advocacy services and rights advice to consumers of and those seeking access to psychiatric services. We work to empower our clients to make informed decisions about their care, treatment and legal rights. We use information, education, negotiation and referral to conduct instructed, non-instructed and systemic advocacy. We conduct public education on these issues. We promote self-advocacy and self-determination.

MANDATE

- To advance the legal and civil rights of psychiatric patients in all provincial psychiatric hospitals 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; and,
- To refer patients, when necessary, to outside community advocacy resources such as community organizations, lawyers or physicians who may offer a second opinion.

VALUES

In providing services to its clients, the PPAO is guided by the following values:

People: We believe in the autonomy of all people and in our right to make informed choices. We value all people as members of our communities and recognize that we may need a variety of formal and informal supports and services in our lives;

Education: We believe education is a powerful tool to effect social change and that this is a part of advocacy;

Community: We believe that with sufficient community options and supports, most mental health consumers are able to remain in their home community if this is their choice;

Process: We believe that the advocate's first responsibility is to act upon the client's expressed wishes and personal choices, and to promote the safety, quality of life and care of clients who cannot instruct an advocate

Independence: We believe that we must be maximally free from actual, potential or perceived conflicts of interest in order to serve our clients more effectively; and

Consumer Participation: It is essential that consumers, to the extent that they want to and are able to, participate and have a sense of ownership in the policy development of the PPAO.



June 6, 2000

The Hon. Elizabeth Witmer
Minister of Health
10th. Floor Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Mrs. Witmer:

On behalf of the Psychiatric Patient Advocate Office (PPAO), it is my pleasure to submit the PPAO's Annual Report for 1999.

The Report reflects that the PPAO diligently continues in its efforts to meet its obligations to advance the rights and entitlements of mentally ill patients through advocacy and rights advice services.

I am also pleased to report that in 1999, the PPAO took part in the Ministry's *Mental Health Law Education Project* by organizing educational sessions for consumer/survivors and their families about patient rights and entitlements under mental health legislation. In the summer and fall of 1999, we held 34 educational sessions in 21 communities across Ontario. A total of 866 individuals comprised of consumers, families and other stakeholders attended these sessions. We thank those community partners who assisted us by hosting these educational sessions in their respective communities.

Through our rights adviser training initiative, I am pleased to report that we were able to train 85 public hospital staff to become qualified rights advisers.

We will continue in our efforts to strike an appropriate balance in Ontario's mental health services delivery.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Vahe Kehyayan".

Vahe Kehyayan
Director



June 6, 2000

Mr. Daniel Burns
Deputy Minister of Health
10th Floor Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Mr. Burns:

Welcome to the Ministry of Health and Long Term Care. It is my pleasure to submit to you the annual report on the activities of the Psychiatric Patient Advocate Office (PPAO) for 1999.

The report summarizes program activities for this period as well as PPAO actions on behalf of patients. These activities demonstrate our commitment to promoting the rights and entitlements of psychiatric patients. It is with great interest that we prepare to work with the hospitals receiving governance of provincial psychiatric hospitals in the coming year. We are pleased to be in a position to assist them to deliver a high quality of care and treatment to those who will require their services.

As the reform of the mental health system moves forward, we anticipate that the issues that will most interest our clients as they prepare for their discharge will relate to the manner in which they receive treatment in the community, and on their ability to access safe and secure housing. These issues, in conjunction with their ability to secure adequate income supports and opportunities for rehabilitation will significantly impact on their quality of life. We look forward to working with our clients and with the Ministry to ensure that the transition to a community based mental health system offers the best opportunities for successful community living for those who are seriously mentally ill.

Sincerely,

A handwritten signature in black ink, appearing to read "Vahe Kehyayan".

Vahe Kehyayan
Director

cc. John King, Assistant Deputy Minister
Health Care Programs

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DIRECTOR'S REMARKS

Once again, it is my pleasure to report to the Minister of Health and Long-Term Care, our clients and their families, and stakeholders on the activities of the Psychiatric Patient Advocate Office (PPAO) during 1999.

Mental health services delivery in Ontario is in the midst of unprecedented change: the divestment of provincial psychiatric hospitals by the Ministry to public hospitals; anticipated reductions in institutional bed capacity; developing capacity for community-based services to accommodate patients following discharge from hospitals; introduction of assertive community treatment; consumer fears that community treatment orders will be implemented; and, plans to introduce a patients' bill of rights.

All of these changes have significant implications to the PPAO, its current mandate, operations and staff, and the delivery of advocacy and rights protection services to a very vulnerable population --- the mentally ill. The PPAO has embraced these changes while continuing to advocate for the rights and entitlements of the mentally ill through individual and systemic advocacy and public education. For example, in response to the divestment of the provincial psychiatric hospitals, the

PPAO will enter into service agreements with hospitals to continue providing advocacy and rights advice services following the transfer of governance. We will continue to address the impact of these changes in conjunction with the development of a mental health advocacy model in a reformed mental health system.

Our mandate continues to be specific to the nine PPHs and the Queen Street site (a former PPH) of the Centre for Addiction and Mental Health. During the past year, the program assisted many patients to self-advocate for their rights. "Best-practice" and "client-centred" policies were developed. Systemic advocacy efforts dealt with several quality of care and quality of life issues for the benefit of all patients in these facilities and in some instances, in all psychiatric facilities. As a program, we ensured that our collective activities remained in line with our "patient first" perspective in view of the profound changes and developments taking place. We have strived to capture and highlight the extent and scope of our activities in our 1999 Annual Report. We are pleased and proud of our achievements, which are primarily due to our staff commitment and diligent efforts.

Technological Developments to Improve Service Delivery:

Since 1998, we have been developing a computerized case management system, which would better track client issues and advocacy functions. The new system will be launched on March 1, 2000 and we expect that it will be a comprehensive tool for recording, reporting, and tracking client services. The system places the PPAO on the leading edge of such technological applications. In addition to the emphasis on individual advocacy, the system will also permit public education and rights advice activity reporting. Its capacity to assist in documentation and reporting of our systemic advocacy efforts is under construction.

The PPAO completed a major upgrade of its technology infrastructure to better serve our clients. We installed new Y2K compliant computer hardware and software in all of our field offices. In addition to this, our website continues to draw visitors from all over Ontario, Canada, the United States, and Europe. In the year 2000, we plan to enhance our website to ensure improved access, and to establish a forum for dialogue on advocacy issues.

Public Education:

As well, 1999 was a productive year in fulfilling our mandate to educate the public on mental health legislation and patients'

rights. In conjunction with the Ministry of Health and Long-Term Care's *Mental Health Law Education Project* initiative, we organized educational sessions for consumer/survivors and their families about patient rights and entitlements under mental health legislation. In the summer and fall of 1999, we held 34 educational sessions across the province in 21 communities across Ontario. A total of 866 individuals, which were comprised of consumers, families, and other stakeholders, attended these sessions. We thank those community partners who assisted us by hosting the educational sessions in their respective communities.

To assist our educational delivery, we developed simple, easy to read rights guides for the benefit of patients and their families. These guides outline the rights of patients in psychiatric facilities under Ontario mental health legislation and specifically address issues such as: 1) involuntary detention in psychiatric facilities; 2) incapacity to consent to treatment; 3) making informed decisions about treatment; 4) the minimal use of restraints; and 5) incapacity to manage property/finances. We have released and distributed these guides and posted them on our website. A sixth guide on "how to complain against health and social service professionals" is in press.

Rights Advice Training:

The PPAO continues to receive requests from Schedule 1 psychiatric facilities for rights adviser training. In response to this demand, in 1999 we organized and held three two-day sessions and trained 85 public hospital staff. As well, we held a special training session in Ottawa for 18 individuals to meet a serious local demand for trained rights advisers. Since 1996, the PPAO has trained 394 rights advisers.

There is an ongoing need for rights adviser training in public hospitals. This is due to staff turnover, absence due to vacation or illness, and the need to ensure rights advisers will be available who will not be disqualified from acting because they are “involved in the direct clinical care of the patient to whom the rights advice is to be given.” Appropriate training is essential to the provision of rights advice in a manner which protects the patient and meets the requirements as set out in the legislation and regulations.

Advocacy and Rights Advice

Activities:

The PPAO’s rights advisers and advocates responded to a total of 7,486 rights advice situations in 1999 to ensure that patients were clear about the decisions made by others about their legal status and that they understood their legal options. The number of rights advice cases in 1999 is

comparable to that of previous years.

Patient advocates addressed 3,456 advocacy issues. These consisted of 1,313 (38%) legal issues; 1,004 (29%) social issues; and 1,139 (33%) therapeutic issues.

Systemic Agenda:

As in previous years, the PPAO pursued its systemic advocacy agenda in 1999. We lobbied the Chief Coroner to hold an inquest into the death of a female forensic patient and the PPAO applied and received standing at the inquest. We received standing because we demonstrated to the Coroner that we had a direct and substantial interest from a traditional private law perspective – as a party who had a direct connection to the deceased. As well, we demonstrated our direct and substantial interest as a public interest group with a provincial perspective and substantial expertise in working with PPH patients. We feel that the inquest recommendations will be conducive to achieving improvements in patient care.

Our other systemic activities are addressed elsewhere in this report. In the next year we will release the results of two current systemic initiatives: monitoring the use of seclusion and restraint in the psychiatric hospitals within our jurisdiction; and, data gathered through a provincially administered housing preference survey completed by consumers.

Provincial Framework on Advocacy and Rights Protection:

In our previous reports we commented on our efforts to develop a provincial framework for advocacy and rights protection services in Ontario. In March 1999, we presented a proposal to the Ministry's Senior Management Committee and received approval in principle that advocacy and rights protection services were to be considered essential elements in a comprehensive mental health services system. As well, we received direction to continue our efforts in the design of the model in tune with mental health reform and the Ministry's "Making It Happen" operational framework for the delivery of

mental health services and supports. We diligently continue our work in this important area.

Future Directions

Over the next year, we will continue to strive to improve our services to our clients. We will also continue to dedicate efforts to improve mental health services delivery in Ontario by vigilantly monitoring issues, and policy and legislation developments from the perspective of patients' rights.



Vahe Kehyayan
Director

SYSTEMIC POLICY ADVISER'S REPORT

The role of the PPAO Systemic Policy Adviser is to promote the PPAO's provincial systemic advocacy agenda. In 1999 this role included assisting the Director, Legal Counsel and program staff on a variety of issues and projects in which the program was involved. Further, the policy adviser takes the lead in responding to issues of concern raised by consumers. The section in this report which deals with issues related to health services restructuring contains some examples of this activity.

Media:

The policy adviser assisted program staff to draft letters to the Editor on issues affecting the rights and entitlements of psychiatric consumers, some of which were published in Windsor and St. Thomas. In addition to this, the policy adviser acts as the program spokesperson on a number of issues and in this capacity was quoted in a National Post story about PPAO opposition to forcing treatment on psychiatric patients. The program's position on this issue was also highlighted in Community Action - a

national publication focused on community services.

During the course of the year the program also responded to an article published in the Canadian Journal of Psychiatry, which addressed mental health legislation and the right to appropriate treatment. The article contained a criticism of the manner in which the PPAO provided rights advice to a patient. Our response was printed in the Journal in June 1999. In it we outlined the legal obligation to provide rights advice as contained in the *Mental Health Act*, in addition to the PPAO's standard of practice in meeting that obligation.

Discharge Planning:

The quality of discharge planning is an important systemic issue for persons receiving long-term inpatient psychiatric treatment. In order to understand patients' experience of the discharge planning process, the PPAO carried out a survey to assist us to identify issues from the patient's perspective. Over a period of six months in 1998, PPAO staff interviewed 180 patients and ex-patients regarding their participation in their discharge planning process. The survey also included PPH staff interviews and community agency responses to a questionnaire.

The results of the survey were posted on our website in May, 1999. One-half of the

patients we interviewed stated that they were unhappy with the preparations made for their discharge. Some of this dissatisfaction came from the aspect of leaving the hospital to live in a boarding home or another type of housing not of their choosing. Other issues were related to the lack of over-all choices available to the patient or a lack of information about what the community had to offer. In addition to these views, some PPH discharge planners reported experiencing frustration in assisting patients due to long waiting lists for good local programs. Further, they reported feeling pressure to discharge patients to substandard housing. Community agency staff voiced concerns regarding difficulties in linking with PPH staff and patients prior to the discharge.

The survey was not designed to be a scientifically rigorous examination of current discharge planning practices and procedures on the sites where the PPAO provides services. However, we feel it is important to formally dialogue with our clients in order to incorporate their perspectives in our systemic advocacy activities. Discharge planning is a crucial process to ensure that patients receive the services that they require once they relocate to the community following an admission to a care facility. As a result of our survey, the PPAO made several recommendations to the Ministry of Health and Long-Term

Care with respect to the process, including that the Ministry ensures the equitable distribution of community mental health resources in all regions of the Province. The PPAO will continue to monitor our clients' concerns with respect to their preparation for returning to their home communities following a period of inpatient treatment.

Health Services Restructuring

Systemic advocacy initiatives undertaken by the PPAO are brought forward in a number of ways including as the result of concerns raised directly by consumers. At times, these concerns are beyond the mandate of the PPAO but are related to the work we do and so we are able to provide information to consumers to assist them in their self-advocacy efforts. Two such issues, related to health services restructuring, were raised during 1999. Another issue was also raised which, while not directly related to restructuring, will impact upon patients discharged from hospitals into the community. Issues such as these will continue to arise in various communities across the province. Clearly, there is a need for community-based mental health advocacy.

- A group of consumers wrote to the PPAO to ask for our assistance in dealing with a program redesign.

While the consumers were receiving services from a facility in which the PPAO does not provide advocacy services, the concerns raised were of such importance that we felt it necessary to offer our feedback and support. The program in question was being restructured to develop new services focused specifically to individuals identified as seriously mentally ill. The people who were already served by the program did not 'fit the definition' and were advised to seek services elsewhere. They felt that they were going to be left without access to support and services for a significant period of time in light of the long waiting lists for community based services. The group wrote the PPAO to request our assistance in their attempt to ensure continued access to mental health supports and services. The PPAO supports the development of additional community services to support those who are seriously mentally ill. However, we are concerned that rebalancing mental health services must not be at the expense of one group in order to meet the needs of another. We corresponded with the group, made several suggestions and, with their permission, forwarded their letter and our reply to the appropriate MOHLTC Regional Director.

- We received a complaint written on behalf of a group of residents in a supported housing program. The residents complained that their program was being changed without their consent or consultation. The residents felt that their quality of life was affected by the changes and that the program's Board of Directors was unresponsive to their concerns. The PPAO advised the residents that there was a process in place to review operating plans for community mental health programs. Where program or service changes were being proposed, the program is required to provide evidence of internal and external consultation prior to imposing changes on program members. We identified several complaint processes available to the group and invited them to keep us informed of their success.
- In November we wrote the Minister of Community and Social Services (MCSS) on behalf of our clients due to changes in the administration of special necessities funding for recipients of the Ontario Disability Support Plan (ODSP). MCSS took over full responsibility for the program from municipalities on September 9, 1999. Our clients reported that the change affected their ability to receive transportation assistance to attend

mental health or addiction day programs or alternative educational or employment programs. Apparently a narrower definition of eligibility for medical travel was being applied which resulted in less access to support programs due to a lack of funds. Our understanding is that the program represented a small investment and we urged the Minister to restore funding, especially in light of the shift to the community delivery of mental health services. In December the Minister responded to our letter and indicated that coverage to attend drug and alcohol recovery groups would be continued and that new requests would be approved where a physician recommended attendance at such programs. The Minister also indicated that coverage for the cost of transportation to day programs, if the benefit was in receipt as of September 30, 1999, would be continued. However, the Minister indicated that new requests for transportation costs to day programs would not be eligible. He suggested that programs could provide costs if funds were available within their budgets or that municipalities could choose to fund these requests through discretionary benefits.

PPAO Staff Activity Reporting

As noted elsewhere, improved computerized data collection and reporting will allow us to track the utilization, efficiency and effectiveness of our services. The staff activity reporting system is currently being tested on site in one location in preparation for full implementation early in the year 2000. In conjunction with the development of the information system, a manual is in development to guide staff training and use of the system and our data collection and reporting policy will be revised to reflect the incorporation of the new system.

Assertive Community Treatment

Following previous staff development events to assist advocates and head office staff to increase our understanding of this treatment approach, we invited a group of experts in developing and delivering assertive community treatment (ACT) to address our staff at one of our program meetings. The subsequent discussion was both lively and informative. Ultimately, we believe it is early in the provincial implementation of this approach to determine the full impact of ACT on the lives of consumer/survivors. We await the results of the Community Mental Health Evaluation Initiative to assist us to more fully develop our point-of-view on this treatment approach from a patient rights

perspective. The PPAO urges, however, that assertive community treatment approaches be developed, implemented and evaluated prior to implementing other, possibly more aggressive, treatment delivery approaches.

Patient Deaths

Our direct involvement in standing in the public interest at a coroner's inquest is addressed elsewhere in this report. On the request of program staff for education on the topic, we invited a representative of the Coroner's office to address us at one of our staff meetings. As a result of that presentation, we are both more aware, and more vigilant, of our duties under the *Coroners Act*. Through consultation between head office and field office staff, we have submitted letters to Regional Coroners regarding patient deaths according to our obligation under the *Act* and have sought standing at another inquest to take place early in the next year. Where we have been publicly involved in such events, we will post information on our website.

Regulated Health Professions Act (RHPA)

Addressing issues raised in task force reports and making submissions in response to proposed legislation is an important function in advancing the

program's systemic agenda. The role of the policy adviser in this regard is to work with a staff team to develop the submission.

In response to the report “*Weighing the Balance: A Review of the Regulated Health Professions Act*” we made several recommendations on how the Act could be improved to ensure that an exemplary level of professionalism exists amongst health care workers. We also provided information on some of the systemic barriers encountered by our clients in their attempts to avail themselves of the protections offered through the RHPA. In general, our clients have reported they feel the Colleges do not respond in a timely manner to their complaints and further, that it takes too long for a matter to be investigated and resolved. Because they reside for long periods of time as in-patients in psychiatric facilities, they also have concerns about a lack of privacy in sending and receiving mail and in accessing telephones. Another aspect of long-term residence in a facility is a reluctance to proceed with a complaint against a health professional. Further, accessibility to the complaint process may be impaired by language or literacy issues or simply by the attitudes of staff in a facility. For example, patients may be told that complaining is a 'sign of illness'. Finally, the stigma of mental illness is so great, our clients have expressed fears that

if a College finds out they have a mental illness, they may not be believed.

Public Guardian & Trustee

Our clients have raised many issues over the years about the services they receive from the office of the Ontario Public Guardian and Trustee (OPGT). Following an exchange of correspondence and a face-to-face meeting with OPGT staff where we addressed the issues, the two offices agreed that our discussions should be made publicly available, as our mutual client concerns are important. The questions raised by the PPAO and the OPGT's responses will be available on the PPAO website early in the year 2000.

Special Projects

In the year 2000, the PPAO will undertake other special projects to canvass the opinions of consumer/survivors on specific issues and to systemically identify the advocacy concerns of our clients. These projects are the result of material developed by PPAO staff and improved through interaction between head office staff and our field office staff. Further, we solicited the views of consumers and clients on our materials in addition to those of providers and family members. Through our consultations, the materials we've developed are more user-friendly.

LEGAL COUNSEL'S REPORT

Role of Counsel

The role of PPAO legal counsel is to provide general legal advice to the program, as well as to assist and advise patient advocates and rights advisers. Legal counsel deals primarily with matters that fall under the *Mental Health Act*, *Substitute Decisions Act* and the *Health Care Consent Act*. In responding to patient questions about the policies, procedures and practice of the provincial psychiatric hospitals, patient advocates occasionally seek legal counsel's interpretation of the rights guaranteed under the *Canadian Charter of Rights and Freedoms*. On occasion, interpretation of the mental disorder provisions under the *Criminal Code* is required.

Systemic Activity

From a systemic perspective, in 1999 the legal counsel explored a number of issues of importance to all of the PPAO's clients. These included examining the protocols for research being done on the forensic psychiatric population, including the vetting of projects by hospital and research ethics committees, and how informed consent is obtained; and various issues surrounding patients' communication rights. A future systemic issue to be addressed is an inequity faced by patients receiving care at a designated psychiatric

facility. The statute of limitations for pursuing an action under the *Mental Health Act* is six months. By contrast, the statute of limitations under the *Public Hospitals Act* is two years.

In April 1999, the PPAO sought and was granted standing at an inquest into the death of a female patient who was admitted to a provincial psychiatric hospital and placed on a forensic unit with nineteen men. This patient became pregnant while on the unit, and died shortly after giving birth. Pursuant to the *Coroners Act*, the PPAO was granted standing at the inquest into her death because of its substantial and direct interest in the issues to be addressed. The PPAO met both the private law and public law tests of standing for the following reasons:

1. the local PPAO office provided services to the deceased, and therefore could be subject to scrutiny at the inquest; and
2. as a public interest intervenor, the PPAO put forward its expertise to assist the jury in making practical recommendations to prevent future deaths in similar circumstances.

Ultimately, many of the recommendations proposed to the jury by the PPAO were

adopted, particularly in relation to the use of locked seclusion, stigma, patient sexuality and the investigation of unexpected pregnancies. The inquest provided the basis for an article in the inaugural issue of the *Journal of Women's Health and Law*, bringing international attention to systemic issues in women's mental health.

PPH Divestment and Service Agreements

In anticipation of the divestment of the provincial psychiatric hospitals, work began in 1999 to draft a service agreement to provide PPAO services for a one-year transition period at the Tier 1 Receiving Hospitals following divestment. The PPAO agreement forms part of the broader governance transfer agreement between the MOHLTC and the Tier 1 Receiving Hospitals.

Public Education

Legal counsel has an ongoing role in providing information and education to individuals and groups outside the PPAO, both informally and formally, through speaking at conferences and publishing in the areas of consent and capacity, mental health, patients' rights and health information. In 1999, these included presentations to the Gerstein Centre, St. George's United Church, Humber College, Osgoode Hall Law School's Pro Bono

Students Program, Lakehead Psychiatric Hospital, delivering a conference paper on patients' access to their health information, chairing a conference on accountability in the health sector, and appearing on CBC radio to discuss systemic issues in women's mental health. In responding to patient questions about the policies, procedures and practice of the PPHs, patient advocates occasionally seek legal counsel's interpretation of the rights guaranteed under the *Canadian Charter of Rights and Freedoms*. In 1998, most of these queries related to communication (s. 2(b)), life, liberty and security of the person (s. 7), unreasonable search and seizure (s. 8), cruel and unusual punishment (s. 12), and equality (s. 15), and whether limiting those rights is justified (saved) under section 1 of the *Charter*. On occasion, interpretation of the mental disorder provisions under the *Criminal Code* is required.

Law Student Supervision

In 1999, legal counsel supervised a pro bono law student. Student initiatives included a review and analysis of Consent and Capacity Board decisions and updating its indexing system, and assistance in drafting an application for standing at an inquest scheduled for March of 2000.

1999 PROFILE OF PPAO ACTIVITIES

Rights Advice

When a patient's legal status changes they are visited by a rights advisor. The rights advisor tells them what the legal status change means and gives them information about what their options are. There are eight mandatory rights advice situations.

Rights advice continues to be a very active process in the 9 provincial psychiatric hospitals (PPH) and the Queen Street site of the Centre for Addiction and Mental Health (CAMH). A PPAO rights adviser is often the first contact a patient may have with the PPAO. In addition to providing information to patients about their rights and options when their legal status changes, rights advisers are able to refer the patient immediately to a patient advocate should the patient wish support, advocacy or assistance with any aspect of their inpatient care. The majority of PPAO rights advisers have been with the PPAO since the inception of the rights advice program in 1986. They are very experienced in communicating rights information to patients in a manner which meets the patient's specific individual needs and in assisting patients to exercise their legal options.

Rights advisers are extremely knowledgeable in mental health legislation

affecting patients' rights. They frequently assist patient advocates with education aimed at consumers and professionals alike. Patients have repeatedly stressed the importance of being able to see a rights adviser who is independent of the facility and free from any perceived conflict of interest. A well functioning rights advice program supports both patients' rights and the legal obligations of the facility on those occasions where patients' rights are circumscribed through unintentional or inadvertent non-compliance with mental health legislation.

The PPAO continues to provide feedback and consultation with respect to complex rights advice issues to rights advisers in general hospitals. In addition, we are available to provide rights advice training on request.

PPAO rights advisers were mandated by law to meet with patients on the ten sites where we provide this service on 7,486 occasions in 1999. This is consistent with the rights advice first contacts in previous years. PPAO rights advisers also conduct numerous follow-up visits whenever circumstances require additional explanations to a person of their rights and entitlements. Of the eight separate circumstances under the *Mental Health Act*

and the *Health Care Consent Act* which trigger a rights advice visit, the majority of contacts (65.8 %) continue to be initiated as a result of certificates of involuntary admission (Form 3) and renewals of certificates of involuntary admission (Form 4). This compares to 68.4% in

1998, 70 % in 1997 and 71% in 1996.

Table 1 below provides a breakdown of the frequency of rights advice provided according to the change in patients' legal status which generated the rights advice visit.

Case Example

A rights adviser reports that her regular practice is to visit patients when they are transferred to the PPH from local Schedule 1 facilities. She meets with the patients to inform them of the services of the PPAO, to inquire into their legal status and to ensure that everything is in order. She reports that on several occasions in the past year she has found that the patient's legal status has changed and that they received rights advice in the Schedule 1 facility before their transfer to the PPH and applied to the Consent and Capacity Board for a review. However, in several cases they have not, as yet, secured a lawyer or applied for legal aid to assist them at the Board hearing. The rights adviser has assisted patients to have representation before the Board in these cases.

Table 1
Rights Advice Annual Totals

Forms / Certificates under Mental Health Act	Number of Rights Advice Visits	Percentage of Total
Form 3 – Certificate of Involuntary Admission	2562	34.2%
Form 4 – Certificate of Renewal	2369	31.6%
Form 21 – Certificate of Incapacity (property)	632	8.4%
Form 24 – Notice of Continuance of Incapacity	309	4.1%
Form 27 – Notice of Informal Admission	2	0.0%
Form 33 (Disclose Clinical Record)	316	4.2%
Form 33 (Examine Clinical Record)	243	3.2%
Form Under Health Care Consent Act		
Notice Form 33 – Notice of Incapacity – Treatment	1053	14.1%
Annual Totals	7486	100.0%

Advocacy

Patient advocates work with patients through the provision of instructed, non-instructed and systemic advocacy services. Instructed and Non-Instructed advocacy are individually based while systemic advocacy involves work that seeks to improve the circumstances of groups of individuals.

Instructed Advocacy

Instructed advocacy is a process which incorporates basic principles of self-determination and client empowerment. As such, it routinely follows client direction and involves the client in decision making. Consistent with the 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 by coming to the advocate. Further to this, advocates inform the client about the scope and limits of the advocate's function, the available options and the possible consequences to the client of exercising available options. When accepting an instruction and conducting advocacy, the PPAO staff does not substitute a "best-interest" approach to resolving the clients' concerns.

Patients in the provincial hospitals requested assistance from advocates for 3,456 issues in 1999. Figure 1 below represents the percentage of patient concerns which fell into the categories of therapeutic, legal, or social issues.

Figure 1
Legal, Social, Therapeutic Issues 1999

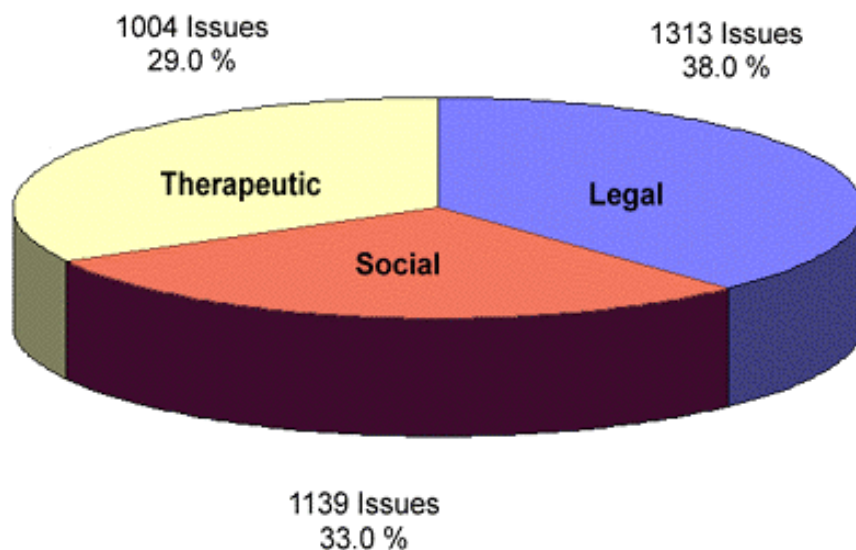
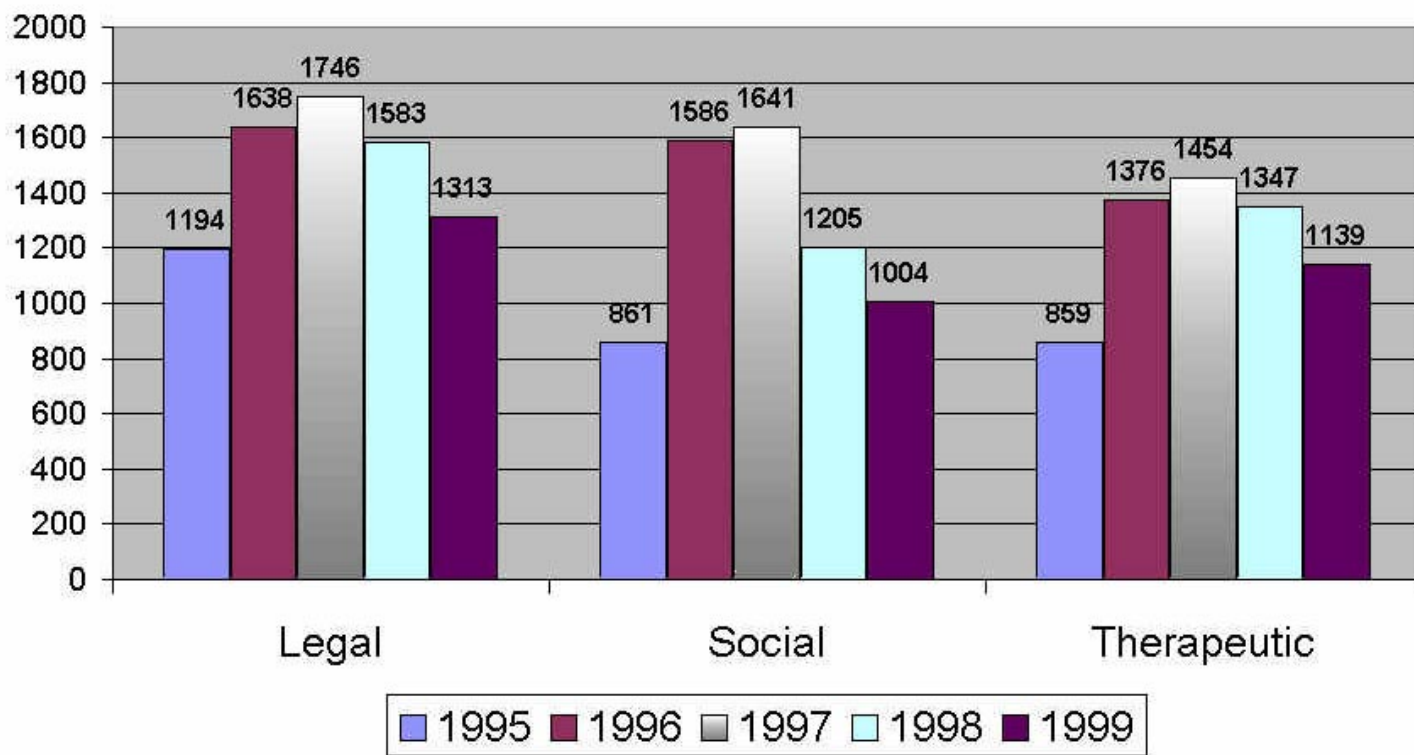


**Figure 2:
Total Instructed Advocacy Issues Addressed**



Therapeutic Issues are defined by a patient's care and treatment while in hospital and range from concerns which relate to admission to hospital, discharge planning, treatment, diagnosis, independent opinions, and issues of staff attitudes and professionalism.

Legal Issues are those which touch upon the administration of the laws which govern the circumstances of a patient's life, care and treatment in the facility. As such, they may relate to access to the patient's clinical record, restraints or seclusion,

abuse/assault allegations, or the quasi-judicial hearings to which a patient is party, appeals which flow from those hearings, questions about rights and entitlement to legal aid, and criminal matters.

Social Issues relate to the finances or the personal property of individual patients and groups, hospital privilege systems, patients' communication rights, access to recreation, educational or employment opportunities, or to cultural and multi-cultural issues.

Table 2
Files Opened by Patient Status

Status	Number	%
Dual Status	2	0.1%
Informal	7	0.3%
Involuntary	1309	59.8%
Other	20	0.9%
Outpatient	290	13.2%
Unknown	7	0.3%
Voluntary	554	25.3%
Total	2189	100.0%

New Files Opened

In 1999, the PPAO opened 2,189 files compared to 2,465 for 1998. A file represents a patient, some of whom may have brought issues to the advocate more than once during the previous year. Table 2 shows a break-down of the total files opened by patient status. Of the 1999 files, 59.8% were with respect to issues brought

forward by patients who were detained involuntarily under the *Mental Health Act* or the *Criminal Code of Canada*. As shown in Table 3, of these “involuntary” patients, 40.5 % were admitted under a disposition order of the Ontario Review Board, and 7 % were admitted under court orders.

Table 3
Files Opened by Involuntary Status

Status	Count	%
Form 1 (Assessment)	73	5.6%
Court Order	91	7.0%
Disposition of the ORB	530	40.5%
Forms 3 or 4 (Involuntary)	615	47.0%
Total	1309	100.0%

When we refer to involuntary status in Table 3, for statistical purposes these are individuals who are in a psychiatric facility as a result of a court order, patients subject to assessments under the *Mental Health Act*, involuntary admissions and patients held as a result of dispositions of the Ontario Review Board. It must be noted, however, that each of these refers to a different type of detention status in a psychiatric setting:

Definitions of Involuntary Status

- a Form 1 (Application for Psychiatric Assessment) allows a facility to detain a person for up to 72 hours (the only legal challenge available to a patient wanting to be released is an application to court, a process which would normally take longer than 72 hours);
- Form 3 (Certificate of Involuntary Admission) or Form 4 (Certificate of Renewal) refers to a person detained as an involuntary patient; the person has the option of opposing this admission at a Consent and Capacity Board hearing;
- a person referred by court order for an assessment can be held for that purpose for 30 to 60 days; a court may order an assessment at any stage of the proceedings against the accused of its own motion, on application of the accused, or in some circumstances, on the application of the prosecutor;
- a person referred by a court order for

treatment can be held for that purpose for 30 to 60 days when a medical practitioner has assessed the accused and found: 1) that the accused is unfit to stand trial; 2) that treatment will likely make the accused fit to stand trial within a period not exceeding sixty days; 3) that without the treatment the person is likely to remain unfit; 4) that there is a benefit of the treatment which outweighs the attendant risks; and, 5) that the treatment is the least restrictive and least intrusive one that could be specified. In this circumstance the accused has the right to be notified of the court's disposition and to challenge it; and

- a person held on a disposition of the Ontario Review Board has been charged with a crime and has been found unfit to stand trial or not criminally responsible on account of a mental disorder. These individuals have a yearly automatic review of their disposition order.

Number of Files Opened by Age and Sex

Table 4 provides the age and sex profile of clients served in 1999. As in previous years where men comprised the greater total of the advocacy case load provincially, in 1999 males represented 61.6% of the total individuals who received advocacy services. Further, women and

Table 4
Files Opened by Age Group & Sex

Age Group	Sex		Group Total	
	Female	Male	Total	%
01-14	1	3	4	0.2%
15-24	43	98	141	6.4%
25-34	176	309	485	22.2%
35-44	275	502	777	35.5%
45-54	205	279	485	22.2%
55-64	66	90	156	7.1%
65-99	61	57	118	5.4%
Unknown	12	11	23	1.1%
Total	839	1349	2189	
%	38.3%	61.6%		100.0%

men between the ages of 35-44 comprised the largest age group (35.5%) accessing services.

In comparing these figures to those found in the Mental Health Supplement to the 1990 Ontario Health¹ Survey, we find, as reported in that document, that individuals determined to be seriously mentally ill in Ontario are more likely to be between the ages of 25-44 (72%) while the gender breakdown is males 45% to females 55%. In looking at the PPAO provision of services for 1999, we find that those within the 25 - 44 age bracket comprise a total of

57.7% of our case load while the gender breakdown in contrast to the 1990 Health Survey figures is 38.3% female to 61.6% male. It is important to remember that the PPAO provides service primarily to inpatients of the 9 provincial psychiatric hospitals and the Queen Street Division of the Centre for Addiction and Mental Health whereas the 1990 survey reviewed the Ontario population at large. This would indicate that although females outnumber males as a percentage of the total population of seriously mentally ill persons in the province, males are more likely than females to seek PPAO advocacy services.

Table 5
Files Opened by Source of Referral

Referral Source	Number	%
External Individuals or Agencies	45	2.1%
Family	39	1.8%
Friends, Co-patients	15	0.7%
Hospital Staff	192	8.8%
Not Known	1	0.0%
Other	3	0.1%
PPAO	82	3.7%
Self	1812	82.8%
Total	2189	100.0%

Advocacy continues to be perceived by patients as an integral component of psychiatric patient services. Table 5 shows that 82.8 % of the files opened were patient self-referrals (compared to 83.5% in 1998). All other figures for referral sources remain relatively similar to those reported for 1998. With the implementation of our computerized data recording system in 2000 we will include both individual

instructed and non-instructed advocacy activities in our reports of advocacy activities.

In conjunction with our planned implementation of issue identification and investigation projects, we expect to increase our activities with respect to the most vulnerable patients in the settings where we provide our services, and that our data in 2000 will reflect this shift.

Table 6, on the following page, outlines the range of options that an advocate has available to address issues presented by clients. The majority of client issues are resolved through providing information and support to clients or through assisting them with forms, correspondence or applications. Assisting clients through consultation and negotiation with front line staff is another important method of addressing patient complaints.

1 *Ontario Health Survey, 1990, Mental Health Supplement*. Ontario Ministry of Health, p. 20, Table 2.

Table 6
Patient Advocate Actions by Issue Category

Action	Action Name	Advocacy Issue Category			Total	%
		Legal	Social	Therapeutic		
10	Information Given	355	192	272	799	23.1%
15	Consult/Negotiation with Front Line Staff	111	304	368	783	22.7%
20	Educational Effort	3	3	1	7	0.2%
25	Referred to Hospital Staff	31	128	100	259	7.5%
26	Referred to Lawyer or Legal Clinic	101	6	3	110	3.2%
27	Referred to Head Office	2	1	1	4	0.1%
28	Referred to Other Agency or Individual	40	34	10	84	2.4%
29	Forms, Application Filed, Assisted with Other written Correspondence	190	29	36	255	7.4%
30	No Action Taken	33	29	28	90	2.6%
31	Consult/Negotiation with Hospital Management	41	46	51	138	4.0%
32	Consult with Head Office/Other Advocates	18	9	4	31	0.9%
33	Consult with External Agency	80	84	29	193	5.6%
34	Consult with Lawyers/Legal Clinic	87	2	2	91	2.6%
35	Options/Consequences Outlined; Instructions given to Advocate	92	50	109	251	7.3%
36	Options/Consequences Outlined; No Instructions given	81	37	73	191	5.5%
37	Provided Support	65	34	37	136	3.9%
38	Client Self Advocated and Resolved Issue with Advice from Advocate	3	16	15	34	1.0%
	Total	1313	1004	1139	3456	100.0%
	%	38.0	29.1	33.0	100.0	

Instructed Advocacy: Case Examples

Unlike clinical staff members who are trained to provide treatment and advice based upon the best interests of a patient, advocates act upon the wishes of the client. This often causes the activities of the advocate to be viewed with concern by clinicians.

However, from an advocacy perspective the advocate is correct in advancing the clients' wishes, even where those wishes may result in serious consequences for the patient.

Example 1

A patient was diagnosed with a very serious bone cancer. He also suffered from a severe psychotic disorder. The patient had been transferred to the facility from a general hospital where it had been determined that he was incapable to consent to both medical and psychiatric treatments. The patient appealed these findings to the Consent and Capacity Board (CCB) which upheld the finding of incapacity to consent to psychiatric treatment but not with respect to medical treatment.

The patient's cancer grew progressively worse until the only prophylactic solution was a below- the-knee amputation. This issue raised serious ethical issues as clinical staff continued to raise concerns about the patient's capacity to make medical treatment decisions. The advocate worked with the client, providing rehabilitation information and access to videos regarding life after a below-the-knee amputation. The patient was not interested in the treatment.

A physician once again assessed the patient to be incapable to consent to treatment of his cancer. The patient again appealed this decision, at which time his incapacity was confirmed by the CCB. The advocate worked with the physicians, the substitute decision maker and the patient to the point where a consensus was reached that, when the patient was able to make his own treatment decisions, he had clearly expressed his wish not to receive treatment. The patient's wishes were respected.

Example 2

A patient complained to the advocate that she had been given the wrong medication, as a result of which, she had been transferred to the intensive care unit of the general hospital. When the advocate discussed her options with her, the patient requested that the advocate look into the matter to ensure that steps were taken to prevent similar incidents in future. The advocate contacted the Coordinator of Clinical Services and the matter was thoroughly investigated by the Nursing Supervisor. Re-education and retraining regarding medication administration was provided to the nursing staff involved. In addition to this, the facility pharmacy agreed to highlight the labels of oral liquid medication bottles and to place an additional label on the bottles before they were sent to the unit. The patient chose to take no further actions in regard to the incident.

Non-Instructed Advocacy

The PPAO advocacy practice continues to be defined primarily by client instructed advocacy. However, this will change over time as we incorporate the systemic investigation and issue identification tools described elsewhere in this report. Non-instructed advocacy is a very important aspect of our work and will be improved upon through the use of these tools. Non-instructed advocacy addresses the needs of the most vulnerable patients who may lack the ability to instruct an advocate. For example, such patients may be those who are in a psychotic state, the advanced stages of Alzheimer's, or those with the most severe developmental or neurological impairments.

In taking on work for patients who cannot instruct, advocates are concerned to uphold their most basic rights and entitlements. Non-instructed advocacy, in contrast to instructed advocacy, requires that the advocate take a "best interests" approach to the issues affecting a patient or group of patients because they do not have the capacity to instruct. However, the provision of this advocacy service is not meant to confer on the advocate the authority to act as a substitute decision-maker. The advocate's action, according to the PPAO's non-instructed policy and procedure, is limited to the attempt to redress an abridgment of a legal right or therapeutic or social entitlement that imperils the incapable clients's health, estate, personal security or human dignity.

Non-Instructed Advocacy: Case Example

A client was an inpatient of a psychiatric unit. Clinical staff were aware that the client was a beneficiary of her recently deceased father's estate. Through their interaction with a family member of the client, the staff became concerned that the family did not intend to advise the client of her rights under the estate. Staff referred the client to the patient advocate for assistance. The client had no understanding of the above situation nor the fact that she was a beneficiary and may have rights under her deceased father's estate. The client could not provide the advocate with instructions. The client had never been assessed as to her capacity to manage her property or make decisions regarding her finances. The advocate discussed with the client's social worker options that might ensure the protection of her rights. These included informing the Ontario Public Guardian and Trustee of the client's situation and her vulnerability, ensuring an assessment of the client as to her capacity to manage her finances and property and referring the client to a lawyer who could ensure that her rights were protected. With the support of the staff, the advocate assisted in arranging for independent legal representation for the client.

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. Systemic advocacy is 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 approach by targeting circumstances that affect patients in general. Systemic advocacy can focus on such areas as law, policy reform and consumer empowerment, or address practices which hinder the appropriate care of patients which, if left unchecked, may violate patient rights and entitlements.

To assist us in this work, our advocates participated in work groups to develop tools to assist us to identify issues from the patient's perspective or to monitor facility based activities. For example, as reported elsewhere, in 1999 we focused on the discharge planning process and implemented a patient survey to receive their feedback about their experience. Descriptions of the project and survey results were posted on our web site. Over the course of 1999 we worked on the development and implementation plan for two more projects to be undertaken in the year 2000. We have been fortunate to have the assistance of one of our advocates who has taken the role of co-ordinator for these projects.

We plan to undertake more work of this nature as we improve our systemic approach to addressing patient quality of care and quality of life issues. As we move in this direction, an inquiry has been made as to whether our work in this regard is 'research' or whether it is simply a formal approach to client issue identification. Indeed, as noted in our Legal Counsel's report, we are very concerned about the issues related to an ethical approach to conducting research in psychiatric facilities. As we move forward in the development of this approach to systemic advocacy, we will undertake to discuss and resolve these issues with administrators, clinicians and research specialists.

Seclusion/Restraint Monitoring Project

As we wrote in 1998, issues related to the use of seclusion and restraint have been fairly constant topics raised by clients of the PPAO. Early in 2000 we will implement the project we have been developing for over a year. The purpose of the project is to identify patients' concerns, policy and procedure concerns and the facility culture with respect to the use of seclusion and restraint. In addition to this we will identify violations, if any, of patients' rights and entitlements under the *Mental Health Act*. We have advised hospital administrators of our plans on this topic.

Early in the new year, we will undertake a 'snapshot' of the use of seclusion and restraint measures on the sites where we provide advocacy and rights advice services. The snapshot will include a review of the total hours of seclusion/restraint over the course of three days. In addition to this we will interview patients about their experience and their understanding of the event. We will also interview clinicians to gain insight on their perspective. Parallel to this process, policies and procedures will be compared. We intend to complete the snapshot look at the use of seclusion/restraints early in the new year.

Housing Preferences Survey

Access to affordable housing is frequently raised by our clients as a barrier to their successful relocation to the community following a hospital admission. We have developed a survey tool to assist us to determine the housing preferences of people who have experienced a mental illness. We want them to tell us what kind of housing they are living in today, and what kind of housing they want to live in tomorrow. People completing the survey are encouraged to provide answers to those questions that apply to their situation. We will also invite community partners to assist us in gathering this information where an organization provides services or supports to individuals with mental illness.

At the same time, the survey is designed to be completely anonymous to ensure every participant has the freedom to provide the information they feel is important. We will use this information to raise awareness, along with housing advocates, of the housing needs of people with mental illness.

Hospital-Based (Local) Systemic Initiatives

In 1999, of a total of 173 systemic files, 43 related to legal issues, 56 to therapeutic issues and 74 as a result of social issues. Advocates reached a total or partially

successful resolution in 47 of these files. As mentioned, the purpose of systemic advocacy is to resolve problems more efficiently than the individual approach by targeting circumstances that affects patients in general. Advocates identify systemic issues in a number of ways. At times it is because of the number of patient complaints they have received on a specific issue, at other times it is as a result of reviewing facility policies and procedures. According to the PPAO's systemic policy, the local advocate makes every attempt to resolve the issue within the hospital in which the concern arose.

Systemic Advocacy: Case Example 1

As reported by the PPAO Legal Counsel, in 1999 the program was involved in an inquest where jury recommendations were made, in part, to address issues related to patient sexuality. The jury recommended that the Ministry of Health and Long-Term Care create a policy that recognized a right to sexual expression. The jury said the policy should be modeled after the Riverview Psychiatric Hospital policy (a hospital in British Columbia) and that each psychiatric hospital should be required to institute the policy and guideline within a stipulated time frame. The Riverview policy includes a capacity assessment regarding a person's ability to consent to sexual activity. Because of this, the jury also recommended that patients have the right to question any assessment that they were not able to consent to sexual activity in the same way they are able to question when a doctor says they are not able to consent to their treatment. The jury made these recommendations in recognition that there should be a uniform policy throughout the psychiatric hospitals in Ontario with regards to sexual activity of long term in-patients. See the PPAO web site for more information on jury recommendations.

Patient advocates, on a systemic basis, are addressing various issues related to the sexuality and sexual expression of patients across the province. These issues range from those specific to sexual expression to ethical issues related to reproduction rights. We appreciate that issues related to sexuality are extremely complex and that clinicians are charged with ensuring the safety of patients. However, we are concerned that patients' safety would be enhanced by access to information and support with respect to sexuality and sexual expression. Advocates across the province are committed to addressing the concerns of patients; what follows is a summary of these:

In one facility, the advocate reports that the hospital has had inconsistent practices with regard to the availability of condoms to patients. Patients either had to buy them through a dispenser, or ask a staff person for a condom if they were not able to afford to buy one. In recognition that patients would have sex with or without using condoms, the issue was addressed in the facility in two ways. First, staff were invited to an educational forum on 'harm reduction models' where attitudes towards sexual expression were discussed. Secondly, condoms were made freely available to patients, in an area where patients congregate, without the necessity of going through a third party.

In another location, hospital staff indicated to the advocate that patients were expressing a concern regarding their safety and that there seemed to be a need for education regarding safe sex, the right to say 'no' and privacy issues. In that facility task groups are developing educational materials for staff and patients and a draft policy has been developed as well. The issue is also being addressed in the context of 'ethical decision-making'. At a different location, an ethical issue relates to sexual expression and public health issues with respect to a sexually transmitted disease.

Two different facilities are at different stages of drafting sexuality policies. On one site a draft policy has been presented to several committees. Final adoption of this policy has not occurred although discussions have been held to discuss the process of staff and patient education in relation to the release of the policy. Our understanding is that the patient council at this facility wishes to set up a safe sex information centre for patients. The advocate has supported this proposal with facility management.

In May 2000 the coroner is to review the progress of the jury recommendations listed above and make a public report on the progress of the implementation of those, and other, recommendations made at the inquest. We look forward to this report and continue to dedicate our efforts to the advancement of patients' rights and entitlements with regard to sexuality and sexual expression.

Systemic Advocacy: Case Example 2

In one hospital, the advocate has been working for some time to address issues related to multiculturalism. A concern was the failure of the facility to provide culturally sensitive psychiatric care and to promote the inclusive recognition of holidays that represent the spiritual and ethnic mix of the patient population. Among the efforts to address the issue has been the adoption of a system to address religious preferences with patients after the admission process, when the patient may wish to discuss such issues. In addition to this, nursing quality standards in this facility now include a component related to multicultural assessments. Staff education sessions have been organized with the College of Nurses to address the clinical needs of staff. Religious holidays are now globally recognized throughout the hospital in an effort to provide more exposure to all staff and patients to the practices of other cultures. Many of these accomplishments have been extremely challenging and difficult to achieve in that the facility is not located in a major centre such as Toronto where more resources to address these issues are available. While the advocate and hospital staff have made many advances in addressing this concern, efforts are ongoing.

Systemic Advocacy: Case Example 3

The advocate received a copy of a letter which had been sent to the hospital administrator from a group of families concerned about the care and treatment received by their family members. The advocate contacted the chair of the Family C.A.N. (Caregivers Action Network) group and obtained further information from them. The chair agreed to involve the PPAO director and consented to have a copy of the letter provided to him. The Director felt that it was important to discuss the issues with the families in person and subsequently he met with approximately 20 family members.

A couple of days later, another meeting was held with family members and hospital officials. The final outcome of this meeting was the development of a Continuous Quality Improvement (CQI) Committee at the hospital. Six of the Family C.A.N. members and the advocate were invited to sit on the Committee. The Committee met over a period of eight months when they issued a final report with recommendations for improving patient care in the facility.

As a result of this process, the Family C.A.N. group has become a resource to the advocate office and vice versa. One of the recommendations from the CQI committee was to establish an advisory committee with respect to psychogeriatric care. This advisory group is now in place.

Systemic Issues Escalated to Head Office

Where advocate efforts to resolve systemic issues are unsuccessful, advocates escalate issues to head office in order to address the issue at the provincial level. Two such issues were escalated to head office in 1999. One issue already addressed elsewhere in this report involves client concerns about the services that they receive from the office of the Ontario Public Guardian and Trustee (OPGT).

The second issue is related to the use of the Form 14 in relation to the rules established in the *Mental Health Act*. Patients are concerned that the confidentiality of their information is not fully protected and that they don't have full control over information gathered about them. For example, when a patient provides third party consent to their clinical record through the use of a Form 14 they cannot restrict access to certain parts of the record that may not be relevant to the release of information. Further, there is no provision on the form for the patient to specify an end date for the consent. With the expectation that the *Mental Health Act* may be opened for amendment in the coming year, the PPAO plans to address this issue in conjunction with any submission regarding proposed amendments.

Education

Education is an important element in the advocacy work that we do. Education is used whenever possible to resolve client issues and concerns and to conduct systemic advocacy. As indicated in our value statement, we believe that education is a key element in social change. The PPAO, as already reported, was formally involved in the *Mental Health Law Education Project* to assist consumer/survivors and their families learn about patient rights and entitlements under mental health legislation. In addition to this special project, our staff provided education both formally and informally both in facilities and in the community. Over the course of the year our staff (rights advisers, advocates and head office staff) provided education to over 1600 community members. We spoke to community agency staff, students, consumer/survivor groups, health care providers and institutional staff. We spoke about patient rights', legislation, advocacy, the clinical and justice systems, other government organizations and processes, and disability rights.

Student Supervision

In addition to working on behalf of clients, qualified advocates are occasionally asked to provide one-on-one education and supervision for students interested in an advocacy placement as part of their professional training. In January 1999, one such student was placed in the PPAO Lakehead Psychiatric Hospital field office. As part of his placement, the student assisted clients with individual advocacy issues and worked on systemic advocacy as well. In addition to assisting a client with physical accessibility issues, and setting up a patient clothing depot, the student organized a task group to identify problems with the recently implemented *Ontario Disability Support Program Act*. The task group, comprised of both community members and

psychiatric consumers, reviewed the legislation, identified problems and reported their finding to the Ministry of Community and Social Services.

The student investigated and researched the need for accessibility to the Ambulance entrance door. This was successful with a button now at the door so patients can enter the building unassisted.

Patient access to clothing was identified as a problem. The student reviewed all resources within the hospital and found that there were a number of areas where a patient could get clothing. The student ensured that all wards were informed of the resources within the hospital.

PUBLIC REPORTS

Since its inception, the PPAO has produced and published a variety of documents and reports, including:

- First Report of the Psychiatric Patient Advocate Office (1984)
- Second Report of the Psychiatric Patient Advocate Office (1985)
- Advocacy in Psychiatric Hospitals: Evaluation of the Psychiatric Patient Advocate Office (1987)
- A Discussion Paper on Determinations of Incompetence(1990)
- Systemic and Non-Instructed Advocacy: Whittling Away at the Paradigm (1991)
- A Guide to Psychiatric Patient Rights (1992)
- The Road to Reform: Where is it Leading Us? (1994)
- PPAO: Report on Client Survey (1994)
- A Proposed Protocol for the Investigation of Allegations of Patient Abuse in Provincial Psychiatric Hospitals (1997)
- Psychiatric Patient Advocate Office: 1996 - 1997 Report
- Psychiatric Patient Advocate Office: 1997 Statistical Supplement
- Psychiatric Patient Advocate Office: Annual Report 1998
- A Rights Guide for Patients in Ontario Psychiatric Facilities:
Involuntary Patients (1998)
An Advocacy and Rights Protection Program (1999)
Psychiatric Patients' Rights under Ontario Health Law (1999)
Making an Informed Decision About Your Treatment (1999)
Incapable to Make Treatment Decisions (1999)
Incapable to Manage Property (1999)
Restraints (1999)

APPENDIX "A"

PSYCHIATRIC PATIENT ADVOCATE OFFICE Human Resource Profile

Category & Hours per week		36.25 hrs	27 hrs.	25 hrs.	20 hrs.	18.68 hrs	Total
Head Office	Director	1					1
	Legal Counsel			1			1
	Policy Adviser	1					1
	Operations Manager	1					1
	Admin Assistant	1					1
10 Field Offices	Patient Advocate	12					12
	Rights Adviser	4					4
	Combined position: Rights Adviser/ Secretary	1	4			2	7
	Secretary			1	3		4
Total		21	4	2	3	2	32

Note: The PPAO has a total of 32 staff (about 28 full-time equivalents)

APPENDIX "B"

Mental Health Act & Regulation 741 Relevant Sections of the Mental Health Act & Regulation 741 with Respect to Patient Advocates and Rights Advisers

Mental Health Act

Definition

1. (1) In this Act, "rights adviser" means a person, or member of a category of persons, designated by a psychiatric facility or by the Minister to perform the functions of a rights adviser under this Act in the psychiatric facility, but does not include a person involved in the direct clinical care of the patient to whom the rights advice is to be given;
- (2) A rights adviser or other person whom this Act requires to explain a matter satisfies that requirement by explaining the matter to the best of his or her ability in a manner that addresses the special needs of the person receiving the explanation, where that person understands it or not. 1992, c.32, w. 20(5).

Authority of Patient Advocates

Section 9 of the Mental Health Act says in part:

9. (1) The Minister may ... appoint persons who shall advise and assist ... persons in all matters pertaining to mental health and who shall have such other duties as are assigned to them by this act or the regulations.
- (2) Any officer or person may at any time, and shall be permitted so to do by the authorities thereat, visit and inspect any psychiatric facility, and in so doing may interview patients, examine books records and other documents relating to patients, examine the condition of the psychiatric facility and its equipment and inquire into the adequacy of its staff, the range of services provided and any other matter he or she considers relevant to the maintenance of standards of patient care.

Regulation 741

Designation of Rights Advisers

14. (1) In the case of each psychiatric facility listed in Schedule 5, the Minister shall designate one or more persons or categories of persons to perform the functions of a rights adviser under the Act in the facility.
- (2) In the case of each psychiatric facility not listed in Schedule 5, the psychiatric facility shall designate one or more persons to perform the functions of a rights adviser under the Act in the facility.
- (3) A designation by the Minister may be revoked by the Minister and a designation by a psychiatric facility may be revoked by the psychiatric facility.
- (4) A designation or revocation by a psychiatric facility shall be made on behalf of the facility by the officer in charge of the facility.
- (5) Only persons who meet the following requirements may be designated by a psychiatric facility to perform the functions of a rights adviser under the Act in the facility:
 1. The person must be knowledgeable about the rights to apply to the Board provided under the Act and the Health Care Consent Act, 1996.
 2. The person must be knowledgeable about the workings of the Board, how to contact the Board and how to make applications to the Board.
 3. The person must be knowledgeable about how to obtain legal services.
 4. The person must have the communication skills necessary to perform effectively the functions of a rights adviser under the Act.

Explanation by Rights Advisers

16. A rights adviser fulfils his or her obligation under this Regulation to explain a matter to a person if the rights adviser explains the matter to the best of his or her ability and in a manner that addresses the person's special needs, even if the person does not understand the explanation. O.Reg. 103/96, s.3

APPENDIX "C"

GLOSSARY OF TERMS

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 lives. It is also a vital component of patient protection, assuring that the vulnerable person's legal and human rights are respected, and that their self-determination, independence and autonomy are maintained. The PPAO differentiates between the concepts of "protection" and "advocacy". "Protection" refers to interventions offered to people with disabilities on the assumption that they are unable to understand their options, express their views or make and take responsibility for choices about their lives, care and treatment. "Advocacy", on the other hand, emphasized a person's capacity for autonomy and ability to make such choices, particularly if offered assistance in understanding the options available, and in communicating personal preferences to others. In the case where a vulnerable person cannot instruct an advocate and is at risk of abuse or neglect, an advocate's intervention may be seen as "protection." Hence, this dimension of "protection" is included within the concept of "advocacy."

Self-Advocacy

Advocacy that is undertaken directly by the individual to achieve a specific goal. This form of advocacy may be enhanced through contact with an advocate who can provide information; resources, and an outline of options and expected outcomes of an individual's actions.

Instructed Advocacy

Advocacy that is undertaken directly by an advocate based on a client instruction. The process is guided by the principles of self-determination, client empowerment and self-advocacy. The advocate outlines options and the client determines the path to issue resolution. The advocate assumes the competency of the client to instruct unless the contrary is indicated.

Non-Instructed Advocacy

In keeping with the principles of self-determination, client empowerment and self-advocacy, non-instructed advocacy is conducted on behalf of an individual who for some reason is unable to instruct an advocate at the given time. Issues may concern the quality of life of an institutionalized person or those where a failure to take action will compromise the health, estate, personal security or dignity of the client.

Systemic Advocacy

Systemic advocacy focuses on issues that affect a broad segment of a particular population. These initiatives may, for example, comprise strategic efforts to change administrative structures and service delivery within the context of psychiatric institutions. This can include law and policy reforms that provide the basis for services provided in the mental health care system. The goal of systemic advocacy is to promote changes that support the legal rights, social and therapeutic entitlements of clients; and to address power inequities inherent in institutional settings.

APPENDIX "D"

Forms Initiating a Rights Advice Visit Under the Mental Health Act and Health Care Consent Act

Form	Rights Advice Situation	Frequency of Application to the Consent and Capacity Board (CCB) by Patient to Challenge Decisions Made
Form 3	A person's status is changed to that of an involuntary patient.	Once per certificate.
Form 4	A person's involuntary status is continued.	Once per certificate of renewal
Form 21	A patient is found to be incapable of managing property.	Once in six months
Form 24	Incapacity to manage property is continued.	Once in six months. The application must also be within six months of the most recent finding of incapacity
Form 27	Admission of a twelve to fifteen year old as an informal patient.	Once in three months
Form 33 (notice)	Notice to a patient of incompetence to examine or consent to disclose their clinical record under the <i>Mental Health Act</i>	No limit in the <i>Act</i> on the frequency of applications
Form 33 (notice)	Notice to a patient of incapacity to consent to treatment under the <i>Health Care Consent Act</i>	Once in six months on a finding of incapacity with respect to the same or similar treatment. Exception if the CCB grants leave to the patient to apply sooner based on a material change in circumstances

A Patient Advocate or Rights
Adviser may be contacted in a Provincial
Psychiatric Hospital at the following numbers:

Brockville	(613) 345-3657
Hamilton	(905) 388-2454
Kingston	(613) 548-5575
London	(519) 455-9380
North Bay	(705) 474-1377
Penetanguishene	(705) 549-3663
St. Thomas	(519) 631-1427
Thunder Bay	(807) 343-4309
Toronto	(416) 535-3959
Whitby	(905) 430-4047

The PPAO's head office is located at:

2195 Yonge Street
6th Floor
Toronto, Ontario
M4S 2B2

Phone (416) 327-7000

Fax (416) 327-7008

Webpage <http://www.ppao.gov.on.ca>

e-mail ppao@gov.on.ca

ABOUT THIS REPORT

The statistical data in this report reflects
program activities for 1999.