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LISTENING

A Review of Riverview Hospital

Ombudsman
PROVINCE OF BRITISH COLUMBIA

LISTENING
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The Ombudsman acknowledges the significant contribution made to this report by present and past patients and families, staff and management of Riverview Hospital and community advocacy groups.

Special mention of and thanks to the AD Patients Empowerment Society, and in particular its President, Roderick V. Louis, all of whom worked tirelessly to improve the lives of the patients at Riverview Hospital, and who made an invaluable contribution to our Report.

This is a report of the Office of the Ombudsman as a result of an investigation that was Ombudsman initiated. While other people have provided us with important information and insights, the findings, opinions and recommendations are entirely those of the Ombudsman.

OPEN LETTER FROM THE OMBUDSMAN MAY 1994

"Listening: A Review of Riverview Hospital" is the result of a year and a half long investigation by my Office into the state of administrative fairness at Riverview Hospital. The investigation occurred because of concerns raised to my Office by patients, families of patients and community advocates about the willingness and ability of Hospital administration to deal openly and fairly with patients advocating on their own behalf or as a group.

"Listening" is a review of a psychiatric hospital in a dynamic period of change, when institutional approaches are being discarded in favour of community based solutions. It recognizes the difficulties involved, and the steps Riverview Hospital is taking to overcome them. The report tries to contribute by showing the central role fairness needs to play in this process, both for Riverview, and for the wider mental health service system. The title embodies the principle that fairness for persons with mental illness starts by enhancing their ability to speak for themselves, and by improving the means by which the Hospital listens to what they say.

A keystone of administrative fairness is the right to be heard. When people are in a psychiatric crisis, living with a long term psychiatric disability, or are unable to function optimally due to the symptoms of their illness or the effects of treatment, they are often discredited and considered unable to participate in decisions affecting their lives. Historically, many practices and procedures were developed on the basis of and despite their non-involvement. Yet what we heard throughout this investigation from patients was their desire to be heard and listened to. In a psychiatric facility, most aspects of a person's life are defined by administrative decisions made by others. This report attempts to outline a model with numerous inter-dependent components, some of which are already being developed using patients' and hospital input, that will enable patient participation in decision-making, both individual and collective.

This investigation provided my Office, indeed any Ombudsman in Canada, with the first opportunity to review, on a systemic basis, the status of the administrative practices of a major psychiatric hospital. The critical issue -- what administrative policies, practices and procedures did the Hospital have to put in place to ensure fairness for patients? The challenge was to articulate the means to achieve fairness for people being served by a public agency who may not be in a position, due to illness or treatment, to hold the authority to account for maladministration.

Over the course of the review, my investigators interviewed over 100 patients, former patients and family members, as well as many community mental health workers, Hospital staff and administrators, and reviewed extensive documentary material. The investigation was to identify both the type of concerns which patients and their families have had with respect to Riverview Hospital, and the capacity of existing channels to respond to those concerns.

In "Listening: A Review of Riverview Hospital," I conclude that Riverview Hospital has not had in place the kind of comprehensive, receptive and fair mechanism for responding to concerns about its service that must exist in a psychiatric hospital. In particular, the report outlines the problems which the Hospital experienced in dealing appropriately with patient collective advocacy, and emphasizes the importance of advocacy in making the Hospital accountable to those it serves.

The Report makes ninety-four recommendations. Important recommendations are that the Hospital take the necessary steps for it to welcome the Patient Empowerment Society (PES), the patient run advocacy body at the Hospital, and that the Ministry of Health fund the budget of the PES so it is properly resourced and at arm's length from the hospital.

There is a significant recommendation that the provincial government appoint a Mental Health Advocate to support and promote advocacy efforts on behalf of individual clients of mental health services at Riverview Hospital and around the Province. The Advocate would be in a position to advocate on important issues in the mental health field, as well as to provide information to an enhanced, resourced, developing network of advocacy services in the community.

The Report comments on and makes recommendations concerning several other major areas of concern identified by patients, families and community advocates. These include a right to review quality of life issues such as privacy and the use of restraints, treatment review mechanisms like the right to second psychiatric opinions and choice of caregivers, and transitional issues around discharge planning. The role of family members and Hospital staff persons as informal advocates for patients is recognized and supported. In the sensitive area of legislative reform of the ***Mental Health Act***, I urge the Ministry of Health to restart the consultative process with interested constituencies to produce needed changes in the ***Act.***

I am pleased to note that Riverview Hospital has itself initiated a number of patient-centred measures and policy reviews during the past one and a half years. Those initiatives include: a concentrated effort by management to address longstanding collective patient's issues; Task Forces on Discharge Planning, Psychosocial Rehabilitation, and Admissions Policy; revisions to Hospital policies on consent to treatment, use of seclusion, obtaining certificates of incompetence, availability of language interpreters (including sign language), and investigations of alleged abuse of patients by staff members; passage of a Patient Sexuality Policy and a Hospital's Charter of Patient Rights, both documents firsts of their kind in a Canadian psychiatric hospital; and the appointment of an Advocacy Project Team (APT). The APT brought Hospital staff, patients, and advocates from the community together to design an advocacy program to support Riverview Hospital patients.

In the Report, I comment on several of these initiatives. Taken together, they represent an impressive effort by the Board of BCHMS, and the staff and management of Riverview Hospital, to promote rather than resist the change to a patient-centred culture at Riverview. This has given us a growing sense of optimism that the findings of our investigation and the recommendations of this Report will be received in a positive climate of change and movement. We have been pleased to observe the commitment of that kind through the course of this investigation. I believe that the climate of this organization is more conducive to change than at any time in the past.

We acknowledge with appreciation, the contribution and commitment of all those people who have assisted my Office during this investigation.

Respectfully submitted,

Dulcie McCallum
Ombudsman for the Province of British Columbia

CHAPTER ONE
OVERVIEW

1. INTRODUCTION

"Listening: A Review of Riverview Hospital," is divided into eleven chapters. The first part of the report contains three chapters. This introduction and a background to the Ombudsman's investigation of Riverview Hospital comprise the first chapter. Chapter Two outlines the principles which guided the investigation and the recommendations in the Report, as well as a discussion of the Riverview Hospital's Charter of Patient Rights which itself embodies a principled approach to patient care and treatment. Chapter Three gives an overview of Hospital operations and programs.

The second part of the Report addresses the concerns expressed by patients, former patients, friends and families of patients about Riverview Hospital, and the internal mechanisms which the Hospital needs to have in place to respond fairly to those concerns. Chapters Four through Seven deal with four substantive areas of concern which were identified in the investigation: legal issues, quality of life issues, treatment issues, and transitional or discharge planning issues. We note that these four areas correspond roughly to the division of patients' rights which appears in the Charter of Patient Rights. Chapter Eight summarizes the response mechanisms referred to in the preceding four chapters, and discusses in greater detail the ways in which Riverview Hospital must change in order to better respond to complaints and concerns of its client groups. In particular, we recommend that the Hospital adopt a comprehensive complaints-handling policy to be coordinated by a new position created at the senior level of administration.

In the third part of the Report, we address advocacy. Whereas the former four chapters reviewed internal processes that are necessary if patients and families are to believe that their voices are welcomed and listened to in Hospital operations, the third part deals with our concern that patients' voices need support from outside the structure of Riverview Hospital if they are to be effective. In Chapter Nine, we examine various sources of informal or natural advocacy on behalf of patients, as well as the need to recognize the patients' collective voice as having a legitimate role. With respect to the latter, we review the troubled history of the Patient Empowerment Society[1] at Riverview Hospital, and explore how the problems revealed in that history might be addressed. Chapter Ten deals with the Provincial government's role in supporting the development of a network of community based formal advocacy services for mental health clients at Riverview Hospital and around B.C. We believe part of that role can be fulfilled by appointing a Mental Health Advocate. Chapter Eleven provides a summary of the recommendations made in the course of the Report.

[1] Throughout this Report, we use this name to refer to the patient collective advocacy body that has existed and been active at Riverview Hospital since early 1991. Originally named the "Patient Council", the body was known as the "Patient Concerns Committee" for over two years until the Fall of 1993, when the members changed the name to "Patient Concerns Society", reflecting their interest in eventual incorporation. As the Report was being prepared for printing, we were advised that the body has now incorporated under the name "AD Patient Empowerment Society", the "AD" standing for "accountable and democratic".

2. BACKGROUND TO THE INVESTIGATION

The Ombudsman's investigation of Riverview Hospital had its origins in a series of incidents which culminated in early July 1992 with the discharge of the chairperson of the Patient Concerns Committee (PCC) from the Hospital against his wishes. The Committee, a patient-run body engaged in collective advocacy on behalf of Riverview patients, had been formed in early 1991. For several months leading to July 1992, tensions between the administration of Riverview and the PCC, and in particular its dynamic chairperson, had been growing. The discharge itself came at the height of these tensions, and occurred in confused circumstances.

Concern over this situation and what it might represent caused a number of community groups interested in mental health issues -- including the Canadian Mental Health Association's B.C. Division, the B.C. Schizophrenia Society, the Mental Patients' Association, the West Coast Mental Health Network, and the B.C. Coalition of People with Disabilities -- to approach the Ombudsman of B.C. These groups told us they were worried that Riverview Hospital seemed unable or unwilling to deal with advocacy efforts of its own patients. Members of these groups had themselves experienced frustration over the years with what they perceived as a lack of responsiveness on the part of Riverview's administration.

The Ombudsman of British Columbia has had jurisdiction over Riverview Hospital since the Office's inception in 1979. Since that time, hundreds of complaints from patients and families of patients have been received, many of them resolved at lower levels of Riverview's organizational structure. We were aware, however, that this large and diffuse organization had not made internal complaints-handling a priority. We were also aware that the Ombudsman of British Columbia had never conducted anything approaching a systemic review of the Hospital's operations, and few if any such reviews had been done of other psychiatric hospitals by Provincial Ombudsman offices across Canada.

For all of the foregoing reasons, the Ombudsman of British Columbia decided to initiate this investigation into Riverview Hospital under the powers granted her by section 10 of the ***Ombudsman Act.*** By so doing, it meant that the investigation did not rest upon or respond to the allegations of a complainant or complainants, as is the case with the great majority of Ombudsman files. Instead, the Ombudsman was able to set the terms of the investigation to address the issues which the community had raised. The investigation was announced in early September 1992.

Over the next several weeks, we engaged in further consultations and research to determine the scope of the issues to be addressed and who we would need to speak with in the course of the investigation. The jurisdiction of the Ombudsman extends to fairness in "matters of administration", which does not include therapeutic issues. This provided the first parameter for our consideration. We decided that the principle matter of administration that needed to be addressed was how and to what degree Riverview Hospital responded to complaints brought to its attention by the various "client" groups it serves -- primarily, present and former patients, and families of patients.

The first client group mentioned, present patients at Riverview, is a group facing unique challenges. Those challenges are evident both in the mental health laws of British Columbia, which permit detention and treatment without consent of hospitalized patients, and in the very illnesses which result in hospitalization. Many individual patients are simply unable, or not in a strong position, to make complaints about the services they receive. For this reason, we realized that the investigation needed to deal with the following matters as well: the systems which are or should be in place to ensure that problems encountered by patients come to the surface and receive attention regardless of whether the person directly affected complains; and, related to this, the sources of advocacy available to Riverview patients. Advocacy is an important way in which people whose voices in society are not listened to can be heard.

We decided that in order to identify how Riverview Hospital responds to complaints, it was necessary to reveal the range of concerns which client groups raise with Hospital operations.

All this is to say that we cast our net broadly. We wanted, generally, to find out two things: what types of problems or complaints client groups experience with Riverview, and what avenues do or should exist to ensure they receive a fair response.

This investigation was intended to ensure that patients at Riverview Hospital are heard. First and foremost, therefore, we wanted to meet and speak with patients and former patients. We considered whether a survey or questionnaire would help elicit the information we sought. We decided it was preferable to conduct personal interviews structured only to the degree that we would cover the same topic areas with every subject. Our hope was that patients would tell us their own stories in their own words. In large measure, they did. The same approach was adopted with the other major client group, family members of patients.

We should also add that our principle focus in the investigation were patients and services in the "adult" division of the Hospital -- i.e., patients between the ages of 17 and 64. While Riverview used to admit children, it has not done so for many years. On occasion, persons aged 17 or 18 may be admitted, but that is increasingly uncommon. Geriatric patients comprise approximately 30% of Riverview's present patient population, but we did not specifically address issues that might be of particular concern to that group and their families. Those important issues remain for future study.

Interviews took place over a period of roughly six months. Most of our interviews took place at Riverview Hospital. A significant number were done in our Vancouver offices. We also travelled to five areas outside the Lower Mainland in an effort to hear the experiences of patients and families: Campbell River, Duncan and Victoria, Prince George, the Sunshine Coast, Penticton and Kelowna. We invited those people who were unable to arrange an interview in person to speak to us by telephone or make written submissions.

We also met with a large number of community mental health workers, and staff and volunteers at community agencies providing mental health services. These people might be seen as secondary clients of Riverview, in that they deal on a daily basis with the outcome of admissions and discharges from the Hospital. We held meetings with staff at three of the Mental Health Teams in Vancouver, and at four Mental Health Centres outside the Lower Mainland. We interviewed several officials with the Mental Health Services Division of the Provincial Ministry of Health.

We endeavoured to meet with staff in all the patient care areas and programs at Riverview. We spoke with many individual staff members to discuss their particular responsibilities, and to hear their concerns and ideas. We conducted detailed interviews with several members of Riverview's senior management on issues of greatest relevance to the investigation. In addition to interviews, we collected and reviewed a large body of documentary material, much of it provided at our request by Riverview Hospital.

A literature survey on issues relevant to the investigation was conducted, for which we wish to acknowledge and thank Professor James Ogloff and graduate student Maureen Olley of the Mental Health, Law, and Policy Institute at Simon Fraser University.

The Report tries to distill what we heard and saw. We give voice to those we met with by placing some of their own words at the side of the text, from Chapter Five on. These quotes give individual views and experiences

of the issues we examined. In the end, however, the Report is our interpretation of what we were told and what we learned. The Ombudsman's role is to ensure fairness in the delivery of public services. What we have sought to do in this Report is describe what administrative fairness requires of a psychiatric hospital.

The principal investigators responsible for this review were Peter Carver and Bill Summersgill of the Office of the Ombudsman of British Columbia.

CHAPTER TWO
FAIRNESS FOR PATIENTS - A PRINCIPLED APPROACH

1. INTRODUCTION

Persons with mental illness historically have not been accorded dignity and respect in our society. They have been shunned, isolated, treated with fear and indifference. Their poverty and homelessness attest to how marginal their lives may be. In many respects, they have been silenced. Much of that silence followed from society's reliance on institutional care for persons with mental illness.

The 19th century witnessed the creation of asylums for persons with mental illness. Originally intended as small home-like residences set in pastoral surroundings named accordingly, asylums represented an attempt to improve the quality of life for people whose symptoms seemed not to be amenable to known forms of treatment. Despite those early intentions, asylums grew in size. They became large government-run institutions, repositories for hundreds and thousands of individuals who lived out lives behind their walls and on their grounds. Riverview Hospital has been an institution like this.

Life at Riverview has been inescapably institutional. The requirements of running a large facility came at the sacrifice of meeting individual needs. Dormitory living, and large common eating areas and day rooms, take away the privacy and sense of personal security that most of us take for granted. The regimentation of the most basic daily activities, from meal times to sleeping times to maintaining a quiet atmosphere on the wards, wears away at individuality. The voice of the individual patient faces imposing barriers in the institutional environment. When the individual's voice has little impact, it grows quieter. It becomes easy not to hear it.

If this Report is about one thing, it is finding ways to support the patient being heard. Often, the best support comes from families and friends -- and so, their voices need to be heard too. Over and over in the course of this investigation we were told by patients, former patients, and family members, that their experience of Riverview Hospital was characterized by feeling not listened to, and by being confused about who did what and why. This was sometimes said in the context of praising individual staff

or Hospital staff as a whole, for their caring and professional attitudes. The problem has been systemic, and institutional.

Riverview Hospital is presently caught up in a whirlwind of change. The Mental Health Initiative of 1990 and the 1991 Report of the Royal Commission on Health Care and Costs entitled "Closer to Home" both speak to the need to move hospital-based health services into the community. Riverview is slated to become a 300 bed facility serving the Lower Mainland, one of four hospitals providing tertiary psychiatric care for the Province as a whole.

The downsizing process is more than a question of reducing the bed count. It requires acknowledging the extent of downsizing, identifying the nature of care and treatment that should be provided in a significantly smaller hospital, ensuring that other programs and their trained staff members find a home elsewhere, and adjusting to serving only one region of the Province.

In addition to planning for this major change in size and function, Riverview Hospital has come under increasing pressure to adopt approaches to patient care and treatment that are less institutional, and more centered on individual patient need. Without making changes in this direction, Riverview Hospital, and the tertiary bed facilities being planned for Vancouver Island, the Interior, and the North, would become increasingly divorced from the developing community mental health service delivery system.

In large part, the patient and family advocacy organizations have been the driving force behind much of this change. The effectiveness of the self-advocacy disability movement, more generally, has provided significant support for the changes in direction.

We do not pretend to have answers to the many difficult questions posed by the transition that Riverview Hospital is undergoing. This Report attempts to make a contribution in the area over which we have jurisdiction -- administrative fairness. Fairness is, to put it simply, about listening. Effective listening encourages people to speak out. We hope this Report will contribute to such efforts at Riverview Hospital.

2. ADMINISTRATIVE FAIRNESS

The Ombudsman has the role of ensuring that the public authorities over which it has jurisdiction act fairly. What fairness requires in particular circumstances may depend on the nature of the activity for which the public authority is responsible. In general, there are two main activities that authorities perform. The first is the provision of services under a mandate set out in legislation and policy. The second is decision-making with respect to the rights and privileges of members of the public they serve.

When we speak of fairness in the provision of services to the public we refer to a number of points related to accessibility of services, and availability of an effective system for receiving and responding to complaints about services:

- the creation of an environment within the service that is inviting for those it serves;
- access to an individual who will record and address a concern;
- the ability to submit a complaint to an office in writing;
- physical accessibility including level entry access, elevators, wheelchair washrooms and designated parking;
- the use of plain and respectful language in all forms of communication, including verbal, correspondence and brochures;
- providing assistance to people who wish to submit a complaint including those who require help; and
- the provision of outreach services, opportunities for individuals to voice concerns in their environment, when the designated place to meet is inappropriate.

Fairness in decision-making calls for somewhat different measures, more procedural in nature:

- notifying affected parties when a decision is to be made;
- giving parties the chance to be heard and make representations before the decision is made;
- applying consistent rules to individual cases;
- giving reasons for the decision made; and,
- affording an opportunity for review or appeal of the decision.

Whether fairness requires all of these procedural protections or others will depend on other factors depending on the nature of the decision to be made; the importance of the interests at stake, the timeliness of decisions and cost.

The Ombudsman of British Columbia produced an Administrative Fairness Checklist which is provided to authorities and the public at large as a guide to assess whether an authority is meeting general standards of fairness. The Checklist encompasses aspects of fairness required in both service delivery, and decision-making.

What is the standard of fairness which a psychiatric hospital will be expected to meet? That is a question that has been front and centre throughout this investigation. The administration of Riverview Hospital is engaged in the provision of services and decision-making. Hospital operations involve a mixture of medical and legal practices. The challenge for those responsible at the hospital is to identify aspects of the treatment and legal requirements that are matters of administration (services and decision-making that are not purely medical or legal) and to perform them fairly. Because something is primarily medical or has a legal aspect to it, does not preclude there being an administrative aspect. An example is Electro-convulsive Therapy (ECT). When ECT, (characterized as an invasive form of treatment) is ordered by a physician, what steps must be in place to meet the requirements of administrative fairness as distinct from any legal standard for consent? Does the patient, for example, have access to a review or appeal of the decision to do ECT?

Compounding this challenge is how to develop fair and just policies without the necessity or threat of complaints being received. The approach must be proactive in order to try to achieve an inherently fair environment. That is to say, patients and families should be invited and enabled to complain to administration and administration must be active about internal quality reviews.

This is an essential and particular requirement for fairness at the Hospital because of the situation in which patients find themselves. People who are periodically disengaged because of a psychiatric disability or treatment side-effects are entitled to fairness and justice even if they cannot demand them. One way to guard against unfairness is to put mechanisms for accountability in place.

Ordinarily, those who scrutinize claims of unfair practices, such as the Ombudsman, rely on people coming forward to report them. This action by the individual can be referred to as self-advocacy. It is natural to advocate on one's own behalf whenever possible. It can be done informally when one pursues an issue for one's own benefit about a matter affecting oneself. Self-advocacy can also be done more formally and collectively, such as through a Patient Empowerment Society. Where individual self-advocacy is not possible to any great extent due to the situation in which patients find themselves, it is essential that enabling mechanisms be put in

place to hold hospital administration accountable for their actions in relation to individuals. This may involve others advocating with or on behalf of the individual. It may be a family member or friend (if the individual has agreed to their participation) or advocacy groups providing support and service to the individual. In the same way a ramp enables a person who has a mobility impairment to be included in a service by accessing a building, advocacy acts as a "ramp" for some people with a psychiatric disability to maximize their inclusion. It is the responsibility of administration to acknowledge the legitimacy of advocacy, to understand the different forms it takes, to accept that advocates have status, and to actively encourage and welcome advocacy for all patients.

Another way in which this can be achieved is to model administrative practices and procedures on a clear statement of principles or code of conduct. This articulation can take the form of a Hospital Mission Statement, a Code of Conduct developed by staff, patients and unions and/or a Hospital Charter of Patient Rights. One or all of these provide a tool by which management and those working to serve patients and their families can measure their policies, practices and conduct.

3. STATEMENT OF PRINCIPLES

In undertaking this investigation, we were aware of the need to develop and articulate the core principles that could serve as a basis for our inquiries and recommendations. We adopted a Statement of Principles. It starts with the recognition that every individual is entitled to be treated with dignity and respect. These principles represent the framework for this Report:

1. Every person is entitled to be treated with dignity and respect.

2. Every person is entitled to have the rights and freedoms guaranteed under the ***Canadian Charter of Rights and Freedoms*** respected regardless of her or his place of residence or disability.

3. Every person has the right to be heard and listened to regardless of disability or method of communication. Where individuals live in a protected environment that restricts their right to make decisions, every effort must be made to enable individuals to disagree, i.e., to say no, except where it can be demonstrated that respecting an individual's choice will jeopardize the safety of the individual or others.

4. Every effort must be made to enable people to advocate on their own behalf and, where necessary, individuals and patients as a collective are to be provided with the necessary mechanisms and supports to make their wishes known and acted upon. Those responsible for decision-making in an institutional setting must recognize the importance and legitimacy of advocacy.

5. Where a person's place of residence restricts mobility and ability to advocate on her or his own behalf, he or she has the right live in an environment that promotes and can demonstrate fair and equitable treatment.

6. All services and supports provided within an institutional setting are to be accessible, physically and intellectually, to those for whose benefit the institution is intended.

7. Where decisions are made that affect the lives of institutionalized people, as individuals or as a group, those responsible for making the decision must include those affected in the decision-making process regardless of any assessment of competency done for other purposes.

8. Any decision-making process must be inclusive. The decision-making process must be accessible, understandable, responsive and expedient to those it affects including individual patients, patients as a collective, families, friends and advocates.

9. Where a decision is contrary to a person's or a group of patients' wishes, those responsible for making the decision shall give reasons for that decision in a clear and accessible form that is understandable and meaningful to them.

10. A mechanism that enables all persons to complain must be in place particularly in an institutional environment where peoples' lives are, in large part, controlled by professionals, treatment, physical setting and medication. The complaint mechanism must not have any threshold criteria based on legal or medical capacity or competency.

11. Those responsible for managing and administering the institutional setting must give priority to being accountable to the patients and their families and to ensuring that the facility is a welcoming place that is open to those it serves, their advocates and the community at large.

12. Those responsible for the treatment and care of people who are labeled mentally ill should demonstrate the optimum level of tolerance, understanding and affection for those they serve to set a standard for the community at large to emulate.

13. Psychiatric services delivered in an institutional setting must be viewed and structured as part of a larger continuum of provincial mental health care.

14. Patients have the right to know. For example, the orientation materials provided to a patient on admission should be reviewed with them again when the patient's situation has improved. Written materials should always be clear and in plain language. Non-written materials such as audio or video cassettes, should also be available. All language used at the Hospital should strive to be respectful and non-ablest.

15. Everyone has the right to self-determination. Every effort should be made by Hospital administration to respect that right to the extent possible. All legal mechanisms that enhance a person's right to be self-determining should be equally available to patients at Riverview Hospital.

4. A PATIENT-CENTERED APPROACH

What the Statement of Principles and the discussion which preceded it intend to present is the outline of an approach to issues affecting psychiatric patients that replaces the institutional culture that has been so predominant. We call the new approach "patient-centered", or "consumer-driven."

These and similar phrases run the risk of being mere buzz words or bureaucratic euphemisms that substitute for making real changes. We intend something more. By patient-centered, we mean an approach that places the patient's whole person at the centre of all the facilities planning, clinical practices, and administrative procedures that are intended to serve the patient. The starting place for designing those is the individual's expression of her or his own voice.

We are not proposing something new. A patient-centered philosophy has become increasingly common in other areas of health care. It corresponds to broader developments in Canadian society.

One such development has been a distinct shift in our society concerning persons with disabilities. In the past the social welfare model viewed them as passive recipients of medical and social services. Constitutional and human rights protections have given strength and status to a legal rights based approach, replacing the old model. `This is reflected in the express protection from discrimination of persons with mental and physical disabilities in the equality rights section [s.15] of the ***Canadian Charter of Rights and Freedoms,*** and human rights statutes such as the British Columbia ***Human Rights Act***. The rights perspective which these documents embody provides that persons with disabilities have a claim to equal respect before and under the law.

Many people, including some mental health professionals and family members, view a rights perspective as being opposed to timely and effective treatment of mental illness. We cannot agree. We do agree it would be a mistake to view individual rights as the full answer to ending the cycle of poverty and isolation, and to providing appropriate treatment. But rights are a starting place. They place the individual holder of rights at the centre of consideration, and require systems intended to serve the individual to justify themselves in that context.

In the mental health field, a corresponding shift has occurred. On the Canadian legal front, the law regarding persons found not guilty by reason of insanity (now referred to as "not criminally responsible for reason of mental disorder"), was wholly rewritten in 1992. The changes afford increased procedural protections, including regular hearings by an independent tribunal, for those detained in hospital after being found not criminally responsible.

Changes have not just occurred in law. The delivery of mental health services is being affected by new thinking. We have been pleased to note that Riverview Hospital has itself initiated a number of patient-centered measures and policy reviews during the past one and a half years. Those initiatives include: a concentrated effort by management to address long-standing collective patients' issues; Task Forces on Discharge Planning, Psychosocial Rehabilitation, and Admissions Policy; revisions to Hospital policies on consent to treatment, use of seclusion, obtaining certificates of incompetence, availability of language interpreters (including sign language), and investigations of alleged abuse of patients by staff members; passage of a Patient Sexuality Policy and a Charter of Patient Rights, both documents firsts of their kind in Canadian psychiatric hospitals; and the formation of an Advocacy Project Team (APT). The APT brought Hospital staff, patients, and advocates from the community together to design an advocacy program to support Riverview Hospital patients.

We comment on several of these initiatives later in the Report. Taken together, they represent an impressive effort by the Board of BCMHS, and the staff and management of Riverview Hospital, to promote rather than resist the change to a patient-centered culture at Riverview. This has given us a growing sense of optimism that the findings of our investigation and the recommendations of this Report will be received in a positive and receptive climate of change.

One significant patient-centered initiative at Riverview Hospital is the Charter of Patient Rights. Before beginning our review of how the patient's concerns can be listened to at Riverview Hospital, we will look more closely at the Charter -- how it came about, what it represents, and how it can be made effective. The Riverview Hospital's Charter of Patient Rights can be found in Appendix I of this Report.

5. THE RIVERVIEW HOSPITAL'S CHARTER OF PATIENT RIGHTS

A. DEVELOPMENT

The process that brought the Riverview Hospital's Charter of Patient Rights about warrants attention. Starting in early 1991, Riverview Hospital staff persons serving on the Patients' Environmental Needs Committee began exploring a rights document for patients, after the PES had requested that the hospital be involved in the development of such a document in 1990. They involved lawyers from the Mental Health Law Program on the Riverview grounds, who provided background research. At the urging of the PCC, they were included along with community advocacy organizations. The result was a Joint Task Force that met numerous times over the following year, producing a draft Charter of Patient Rights for presentation to Riverview Hospital through its policy committee structure in the Spring of 1992.

As the draft Charter entered those policy channels in mid-1992, a lapse in communication occurred. The Hospital put in place an internal process to review and revise the Joint Task Force's draft in order to present a document for the Board of Trustees of BCMHS's approval. There had been no question from the outset that for the Charter to become a reality, it ultimately had to be "owned" by Riverview Hospital and those responsible as policy.

The internal review process did not maintain contact with the Joint Task Force. When a revised draft Charter emerged from that process in early 1993, several Task Force members, including former patients and community advocates, objected that changes had been made without their further input or advice. A renewed consultation process occurred through the remainder of the year. This included open forums sponsored by the PES for Hospital patients in which management participated. Significant changes were made to the document as a result of these consultations, particularly with respect to strengthening several important patients' rights. In February 1994, the Board of Trustees of BCMHS approved the Charter of Patient Rights which appears in Appendix I.

The process is instructive. It shows the value of involving patients, former patients, and those in the community interested in mental health issues, in Riverview Hospital planning and policy formation. The pitfalls of not maintaining that involvement once it has begun were also made evident. In the end, the views of those constituencies, while sometime challenging for the Hospital in the short run, helped develop an improved product.

B. TEXT

We wish to make only a few brief comments on the contents of the Charter at this point. Several sections of the Charter, including rights "to a second medical opinion" (II, 5) and "to choose caregivers and care environment where possible" (II, 4) are discussed later in the Report.

In general, we believe the Charter is a strong document, and compares favourably to other institutional rights models of which we are aware, including the recommended Bill of Rights set out in the U.S. ***Patient Protection and Advocacy Office*** legislation. The Charter refers to an annual review of its provisions through a consultative process. Outstanding issues raised by the Patient Empowerment Society, and noted by the Board of Trustees at the time of final approval, should, in our opinion, be considered as part of that review.

The Hospital's Charter of Patient Rights is divided into three Parts:

- Part I: Quality of Life/ Social Rights;
- Part II: Quality of Care/ Therapeutic; and,
- Part III: Self-Determination/ Legal Rights.

The presentation of this Report closely tracks that structure, as we proceed to look at legal, quality of life, and treatment issues in Chapters 4, 5 and 6, respectively. In Chapter 7, we look separately at issues involved in discharge planning, which the Charter incorporates into "Quality of Care." Just as the drafters of the Charter did, we identify these areas as the major dimensions of an individual's experience as a patient at Riverview Hospital. As is evident, the text of the Charter is quite comprehensive. Many of the issues which are discussed in the balance of this Report can be related to rights in the Charter. This means that many complaints patients may have in these areas will be able to be characterized as alleged violations of the Charter. For that reason alone, the questions of how and by whom the Hospital's Charter of Patient Rights is to be interpreted and enforced are crucial.

C. ENFORCEMENT

Section III, 10 of the Riverview Hospital's Charter of Patient Rights states that patients have:

> *"The right of access to an independent body to investigate violations of patients' rights."*

The question of how the Charter should be enforced has troubled a number of people, including advocates for patients and Hospital staff members. We think it useful to make a few comments about "enforcement" in this report.

First, giving meaning to the rights contained in the Charter presupposes a process of interpreting and enforcing the rights. Experience with the document will assist in understanding of what each right means in different circumstances. Does "the right to privacy" require that every patient have a single room? Does it mean that a patient who is bothered by the constant talking of another patient can require staff members to restrict the movement of that patient? Developing meaningful interpretations of rights that can be applied consistently and instances is a process that develops over time.

Second, the Hospital's Charter is not a law, but a policy of Riverview Hospital. Hospital policies can be changed, or unilaterally withdrawn in their entirety, by the hospital. The success of the Charter therefore depends, first and foremost, on the commitment of Riverview Hospital to its stated intent and principles. It is this commitment which defines where the primary responsibility for dealing with alleged violations of the Charter lies -- with Riverview Hospital itself. The Hospital needs to engage in a coordinated implementation of the Charter if it is going to be effective. The coordination should involve an ongoing, proactive interpretation of the Charter's terms, a consistent process for applying them to individual cases where appropriate and a program of familiarizing staff and patients with both.

The "independent body" referred to in Section III, 10 of the Charter could be the Ombudsman of British Columbia. The independence of the Ombudsman permits arms-length investigation of individual complaints, review of internal investigations, and the ability to recommend change. This Office views the Charter positively as providing a set of standards with which to measure the fairness of administrative and patient care matters at Riverview Hospital.

In addition, there may be a need to develop a review body specifically charged with the ability to decide on under Riverview Hospital's Charter of Patient Rights. This could be done through an expanded Review Panel jurisdiction, as we also suggest in our discussion of restraint measures in Chapter Five. It would be appropriate to create this specific jurisdiction by incorporating a Charter into a revised ***Mental Health Act,*** as we recommend in Chapter Four.

Our closing comment is that a Hospital's Charter of Rights should not merely be seen as a list of rights whose violation carries with it various penalty-like consequences. It should serve more as an institutional framework or strategic guide to demonstrate a commitment on the part of the entity to live up to certain norms of conduct. More will come from a positive commitment of that kind, than from the enforcement of violations of rights. The Charter involves a commitment by Riverview Hospital. We and others look to Riverview to fulfill that commitment by adopting patient-centered policies in many areas of the Hospital's operations, and acting upon them accordingly. We have been pleased to date at the level of commitment demonstrated through the course of this investigation.

RECOMMENDATIONS

2-1 That Riverview Hospital develop and implement a comprehensive implementation program of the Riverview Hospital's Charter of Patient Rights that will include staff training and familiarization of patients and families with the contents and purposes of the document. The process should include incorporation of this information in orientation materials for all new staff, patients, and families of patients.

2-2 That Riverview Hospital ensure a coordinated approach is taken to applying the Hospital's Charter of Patient Rights to particular incidents and issues within the Hospital, including an accessible system for receiving allegations of violations of the Charter, investigating into the facts, interpreting the rights contained in the Charter and applying them to the particular situation, and determining an appropriate course of action on conclusion of an inquiry. The Hospital should also use the Charter as a guide in the development and audit of all Hospital policies. Responsibility for some or all of these coordinating functions may be assigned to the recommended new position of Patient Relations Coordinator at Riverview Hospital, discussed in greater detail in Chapter Eight.

CHAPTER THREE
RIVERVIEW HOSPITAL - FACTS AND FIGURES

1. INTRODUCTION

Riverview Hospital is one of the oldest and largest hospitals in British Columbia. The Hospital is located in Port Coquitlam, 20 miles east of Vancouver on the Lougheed Highway. Its over fifty buildings occupy 254 acres of land overlooking the junction of the Coquitlam and Fraser Rivers. Riverview remains the sole "Provincial mental health facility" as that term is defined in the ***Mental Health Act.*** As such, it admits persons from all across B.C. into its specialized inpatient assessment, treatment and rehabilitation programs for those with serious mental illness.

The Hospital opened on April 1, 1913 and was known as "The Hospital for the Mind at Mount Coquitlam." The Hospital grew from 450 patients to a peak population of 4,306 patients in 1956. Staff numbered 2,000. In a sense, the Hospital, isolated from the Lower Mainland as it then was, formed its own community.

Since the early 1960's the Hospital's population has declined to its present level of about 850 patients. Many factors have contributed to this, including: advances in psychiatric treatment including the development of new medications; increased emphasis on the shift from hospital to community-based delivery systems; and the establishment of psychiatric units in acute care hospitals. The Mental Health Plan announced in 1990 calls for the downsizing of Riverview to a 550 bed tertiary care facility by the year 2000, 300 of which will serve the Lower Mainland.

2. ADMINISTRATION AND BUDGET

Prior to 1988, Riverview was operated directly by the Provincial Government. In 1988, the Government created a non-profit society -- the British Columbia Mental Health Society (BCMHS) -- and gave it the task of running Riverview pursuant to the ***Mental Health Act*** and the ***Hospital Act.*** However, the Government retains considerable influence and control. The Minister of Health appoints the Board of Trustees of BCMHS, and the Trustees are the Society's only members. The first Boards were composed of senior provincial civil servants in the health field. In 1992, the Minister of Health fulfilled a policy commitment by appointing a community-based Board, which included six consumers of mental health services and family members.

The BCMHS leases the buildings on the 254 acre Riverview site from the British Columbia Buildings Corporation (BCBC), a Crown Corporation. BCBC provides housekeeping, janitorial and building maintenance services for the buildings, as well as building and grounds security. BCBC staff do not participate in escorting patients or providing patient security, but they do receive training concerning physical intervention in critical incidents. BCBC is, in effect, Riverview Hospital's landlord. While BCMHS and Riverview have a lead role in planning for the proposed 300 bed tertiary care facility for the Lower Mainland, BCBC has planning authority over the Riverview lands. Wholly owned by the Provincial Government, BCBC does its planning in consultation with Government, particularly the Ministry of Health. Leases between BCBC and BCMHS, covering almost all buildings on the site, are for a period of five years.

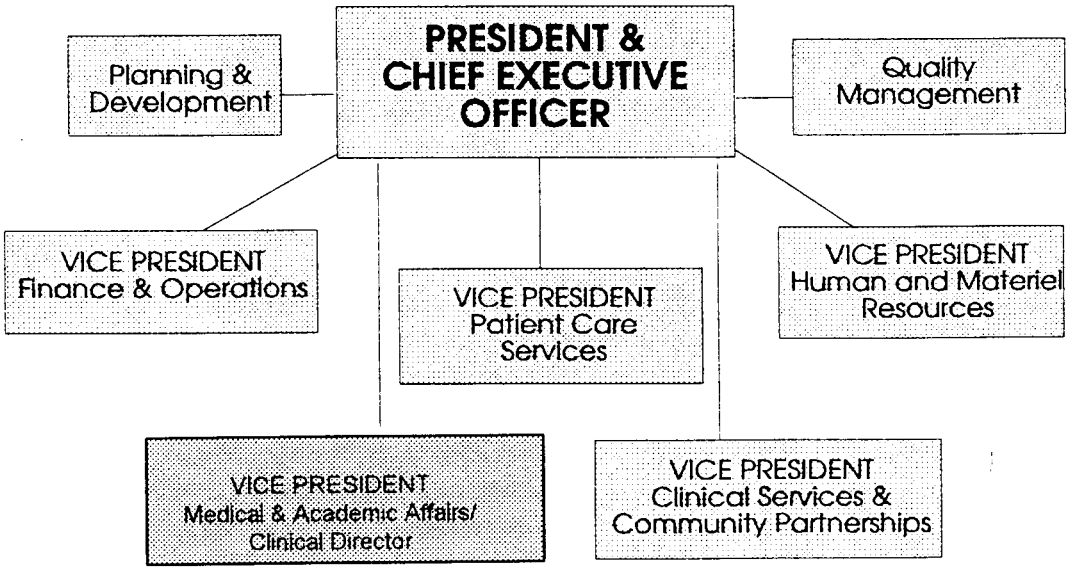
BCMHS originally had a mandate that extended beyond Riverview Hospital to several community mental health programs, including one that served persons with a dual diagnosis of mental illness and mental handicap. Responsibility for those community operations have returned to the Mental Health Services Division of the Ministry of Health. BCMHS's sole responsibility now, is Riverview. In this Report we use "Riverview" and "BCMHS" interchangeably.

The 1993-1994 operating budget for the BCMHS is $104,336,639. Two years earlier, in 1991-1992, the operating budget was approximately $112,000,000. By far the greatest source of funding is the Mental Health Services Division. Physicians' sessional fees are paid by the Medical Services Plan. BCMHS receives a small portion of its revenue from per diem charges paid by informal (voluntary) patients who meet the criteria for ability to pay.

3. HOSPITAL ORGANIZATION AND STAFFING

The Board of Trustees engages a President and Chief Executive Officer to administer BCMHS and thus the Hospital. Senior administration is composed of the President and several vice-presidents responsible for different operational areas. Together they form the Hospital's Management Committee. It's senior administration is depicted in the following diagram:

DIAGRAM 1: RIVERVIEW HOSPITAL ORGANIZATION



April 1993

Riverview Hospital is one of the largest employers in the Coquitlam/Port Coquitlam area, with a staff of approximately 1,800. With the exception of excluded managerial staff positions, Riverview staff are unionized, and include members of the British Columbia Government Employees Union, British Columbia Nurses Union (RNs), Government Professional Employees Association and Union of Registered Psychiatric Nurses (RPNs). Job classifications of the employees at Riverview are varied and include social workers, financial officers, administrative officers, secretaries, laboratory assistants, computer operators, trades persons, laboratory and clinical technicians, psychologists, teachers, dentists, pharmacists, food service workers, and others.

Staff involved in key patient care areas include:

Social Workers	32
Health Care Workers	364
Registered Nurses (BCNU)	132
Registered Psychiatric Nurses	555
Psychologists	14
Activity Workers	46
TOTAL	1143[2]

Medical staff comprises a total of 23 psychiatrists and 32 general practitioners most of whom work on a sessional basis for Riverview Hospital. A session is a 3 1/2 hour time block. Calculated on the basis of 10 sessions/week, Riverview has 16 psychiatrist and 25 general practitioner Full Time Equivalents.

[2] Figures available in August 1993

4. IN-PATIENT PROGRAMS

Riverview Hospital's clinical programs are organized into three Divisions: Adult, Community Psychiatry, and Geriatric.

■ Adult Division

The Adult Division is the largest of the three Divisions, and occupies wards in the two five-story red brick buildings still operating, Centre Lawn and East Lawn, as well as wards in the building which houses the medical hospital on the grounds, North Lawn. The Division admits patients 17 years and older. Virtually all admissions to the Division are made by referral from general hospitals across B.C.

□ Acute Assessment and Treatment Program (AATP)

The Acute Assessment and Treatment Program provides services to patients requiring hospitalization during the acute phase of their illness. Patients are admitted from psychiatric units in general hospitals. The average maximum stay in AATP is three months, after which the patient is discharged or transferred to another Program area in the Hospital. Typically, patients in AATP have a history of repeated short term admissions to hospital.

The Program consists of 120 beds on five wards, including one locked ward, in Centre Lawn. The locked ward is the Intensive Care Unit, which has 20 beds for patients requiring stabilization or exhibiting disturbed behaviours. Ten beds in ICU are used for patients from general hospitals. Patients return to the referring hospital following stabilization. The other ten beds are utilized by Riverview patients transferred from other wards.

□ Continuing Treatment Program (CTP)

The Continuing Treatment Program provides treatment for patients whose conditions require longer term treatment and rehabilitation. The Program consists of 11 wards of 25 beds each in the East Lawn building. Each of the 11 wards is divided into rooms with five to seven beds. Five of the 11 wards are locked. The CTP previously occupied wards in Crease Clinic, a building closed in 1992, as well as in East Lawn. Many patients in the CTP have been at Riverview for several years.

□ Organic Brain Syndrome

This program consists of 85 beds on three wards in North Lawn. The Organic Brain Syndrome Program (OBS) provides treatment and care of patients who have conditions related to or caused by brain trauma or chronic disease. As yet, few facilities are available to adequately support these individuals in the community, many of whom have high physical care needs.

■ Community Psychiatry Division (CPD)

The Community Psychiatry Division provides more intensive rehabilitative and social learning skills for patients moving toward a return to the community. The Division has approximately 90 patients in two wards, Fernwood and Brookside. Each ward occupies its own building on the Riverview grounds, and provides single and some double rooms for patients. The CPD has a bridging program with the Coast Foundation, a non-profit society that operates housing and vocational services for clients in Vancouver. A group of patients from the CPD goes to the Coast Clubhouse every day as part of their program.

■ Geriatric Division

The Geriatric Division at Riverview Hospital offers services to persons sixty-five years of age and older who require psychiatric treatment and/or behavioral management which cannot be provided elsewhere in the Province. Referrals for admission to the Division are made from the community as well as from general hospitals.

The Division is comprised of ten wards varying in size from 20 to 31 beds for a total of approximately 300 beds, housed in what formerly was Valleyview Hospital at the eastern end of the Riverview grounds. The Geriatric Division is divided into five program areas:

- Psychotic & Affective Disorder
- Community Reintegration
- Behaviour Stabilization
- Aggressive Behaviour Stabilization
- Geriatric Acute Assessment and Treatment
- Psychogeriatric Extensive Treatment

5. PATIENT PROFILE

As of March 31, 1993, Riverview Hospital housed 819 patients, 527 (64%) men and 292 (36%) women. The Geriatric Division had 265 patients, almost evenly divided between men and women. Patients were admitted from every mental health region of the Province, but the majority came from the Lower Mainland and Fraser Valley, as these figures for 1992/93 show:

ADMISSIONS 1992/93

REGION	# PATIENTS	%
Greater Vancouver	373	44
Burnaby	42	5
Fraser Valley/North Shore	302	35
Vancouver Island	41	5
Thompson-Okanagan-Kootenay	41	5
North	39	5
Other	19	2
TOTAL	**857**	

Patients discharged during the same period were recorded as returning to these areas in roughly the same percentages.

Over the first eight months of 1993, an average of 62% of patients were involuntarily detained under the ***Mental Health Act.*** The figures for involuntary admissions varied widely amongst program areas; for instance, 81% of patients in the Acute Assessment and Treatment Program were involuntary, as opposed to 52% in the Continuing Treatment Program, and only 20% in the Community Psychiatry Division. Ages and average length of Hospital stay also varied widely amongst Programs. In the Continuing Treatment Program, 48% of patients were 45 years or older and only 9% were under 30. The corresponding figures for the Acute Program were both 27%. Average length of stay in the Continuing Treatment Program was approximately eight years as opposed to one and a half months in the Acute Program.

CHAPTER FOUR
LEGAL RIGHTS

It is important to understand the legal context within which mental health services, especially those available in hospital settings like Riverview, are provided in British Columbia. That context is one of compulsion. The law creates a fundamental imbalance in power between those providing the services, and those receiving services. It may be that the intent of the statute can be rationalized but nevertheless this imbalance is the reason for the need to ensure fairness governs the actions of service providers. This is the starting point for the study.

The patients we interviewed did not raise many concerns about avenues open to them for pursuing their legal rights. Concerns about legal rights tended to come from family members and community mental health workers, some of whom believe the pendulum has swung too far in the direction of patients' rights.

The most common complaint that the Ombudsman receives from patients in mental hospitals is "I want to be discharged." The ***Mental Health Act*** is the only legislative authority apart from the ***Criminal Code*** and related criminal statutes which permits detaining individuals against their will. The ***Act*** authorizes one further action by the state that is unique in our legislative and common law tradition: giving medical treatment without the patient's consent, even against the patient's express objection. In this chapter, we look briefly at these laws, the mechanisms in place to ensure respect for individual rights, and current legislative proposals that might change this system. We also touch on three other issues of legal significance to psychiatric patients in this Province: guardianship; civil legal proceedings; and, access to information on legal rights.

The issues raised by the ***Mental Health Act*** are difficult and controversial. We appreciate and respect the deep feelings that exist on all sides of these questions. We have kept them in mind in writing this chapter, and the Report as a whole. Our concern, however, is that administrative procedures involved in protecting legal rights need to be fair to the affected parties. Our general impression is that Riverview Hospital patients are well served by existing legal processes. A significant gap in fairness is evident respecting procedural protections with respect to overriding a patient's refusal to consent to treatment. We make recommendations on that and several other points.

1. THE MENTAL HEALTH ACT

A. INVOLUNTARY DETENTION

Central to present mental health legislation in British Columbia is the "police power" contained in the ***Mental Health Act,*** RSBC 1979, c.256, that authorizes the involuntary detention in hospital of a mentally disordered person, on certain defined grounds. The power is set out in section 20 of the ***Act:***

"20. (1) On receipt of 2 medical certificates completed by two physicians in accordance with subsection (3), the director of a Provincial mental health facility may admit a person to the facility and ***detain him in it.***

(3) Each medical certificate shall be completed and signed by a physician...who has examined the person whose admission is requested not more than 14 days prior to the date of admission and shall set forth

(a) a statement by the physician that he has examined the person whose admission is requested on the date or dates set forth and is of the opinion ***that the person is a mentally disordered person;***

(b) in summary form the reasons on which his opinion is founded; and

(c) ...a separate statement by the physician that he is of the opinion that the person whose admission is requested

(i) ***requires medical treatment in a Provincial mental health facility;*** *and*

(ii) requires care, supervision and control in a Provincial mental health facility ***for his own protection or for the protection of others."***

(emphasis added)

Section 21 of the ***Act*** states that certificates can be renewed by the director of a facility or an authorized physician. The original certificates are effective for one month, with renewals effective for consecutive periods of one month, three months, and six months thereafter. Section 19 provides for "informal" or voluntary admissions to mental health facilities for "mentally disordered" individuals who request such admission, and who may not otherwise be certifiable.

In quoting section 20, our emphasis was added to the key points about the power to detain: it can only be done on the basis of medical opinion, and that opinion must find three things to exist:

- a mental disorder[3] ,
- a need for hospital treatment, and
- that the individual is in need of protection, for her or his own or others' sake.

Although the opinions must be given by physicians, the definition is nevertheless a legal one, and is ultimately subject to judicial interpretation.

Criteria for certification have long been a subject of controversy. Many individuals and groups believe the criteria should be narrowed, so that fewer people are subject to being held in hospital against their will; many others would like to see the criteria broadened, so more people who do not recognize their need for hospitalization could receive it. Different jurisdictions draw the line in different places.

The Supreme Court of British Columbia recently determined that the admission criteria in the ***Mental Health Act*** do not violate individual rights of liberty and security of the person, and of freedom from arbitrary detention, contained in the ***Canadian Charter of Rights and Freedoms***, and so are constitutionally valid. The Court in ***McCorkell v. Director of Riverview Hospital et al*** (1993) 81 BCLR (2d) 273 rejected the contention that criteria of "dangerousness" to self or others would be the only constitutionally valid basis for detention of the mentally disordered.

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[3] Section 1 of the ***Mental Health Act*** defines "mentally disordered person" as "a mentally retarded or mentally ill person", and goes on to define each of those terms:

"mentally retarded person" means a person

(a) in whom there is a condition of arrested or incomplete development of mind whether arising from inherent causes or induced by disease or injury, that is of a nature or degree that requires or is susceptible to medical treatment or other special care or training; and

(b) who requires care, supervision and control for his own protection or for the protection of others".

"mentally ill person" means a person who is suffering from a disorder of the mind:

(a) that seriously impairs his ability to react appropriately to his environment or to associate with others; and

(b) that requires medical treatment or makes care, supervision and control of the person necessary for his protection or for the protection of others."

The inclusion of "mental retardation" as a "condition" for which detention under the ***Act*** was available, resulted in the inappropriate placement, often as children, of many persons with mental handicaps at Riverview Hospital over the decades. Perhaps as many as 20 such individuals still reside at the Hospital, and face extraordinary difficulty moving into community settings, in large part because of the effects of institutionalization. Both in this respect, and in other wording that fails to reflect a respect for persons with disabilities, this definition is out-moded and should be revised.

The ***Mental Health Act*** provides two formal mechanisms by which a patient can challenge her or his involuntary detention in a mental health facility. The first, under section 27 of the ***Act***, is by application to the Supreme Court of British Columbia. The second is by application to the Review Panel, an administrative tribunal with jurisdiction to review detentions. We look at each briefly.

■ Application to the Supreme Court of British Columbia

Every involuntary patient has the right to ask a Supreme Court judge to review the basis for her or his detention, and to order a release if grounds for detention do not exist. It is rare for a section 27 application to be made. In fact, in the past two years, we are aware of only two such applications.

There are obvious reasons why involuntary patients rarely go to Court to challenge their certification: lack of representation, and expense. It is difficult to go before a court and succeed without being represented by a lawyer. This is true of most legal issues, but doubly so where expert medical opinions are likely to play a large role. At present, the Legal Services Society has not placed representation by lawyers for section 27 matters on its tariff for civil law matters. A patient therefore can obtain a lawyer only through private arrangement, or by interesting a non-profit law clinic in the merits of her or his case. In addition, the Supreme Court rules require a guardian ***ad litem*** to be appointed for an "incompetent" person which may act as a barrier to a person initiating a section 27 application.

Appearing without counsel is not a realistic option for an individual whose competence may be the very issue before the court. Court proceedings are of a formal and technical nature. It is not surprising that patients in a mental health facility generally lack the resources or patience to seek review before the Court.

■ Review Panels

A second means of reviewing involuntary detention exists under the ***Act.*** Section 21 of the ***Act*** gives this jurisdiction to the Review Panel, an administrative tribunal composed of lay and expert members. Every involuntary patient is entitled to apply for one Review Panel hearing during the course of each certification, including renewal periods. The sole question for the Review Panel to determine at a hearing is "whether or not [the patient] should continue to be detained."

Individual panels are composed of three members -- a chairperson, a physician appointed by the hospital where the patient is detained and a person nominated by the patient. The Minister of Health appoints the list of chairpersons. Decisions are made by majority vote of the three panel members. By Regulation, the Review Panel must hold a hearing on a patient's status within 14 days of an application being filed, or within 28 days if dealing with renewal certificates of three or six months. Panel chairs may summon witnesses, and anyone may apply to be heard by the Panel on the basis of having relevant evidence. Hearings are held ***in camera,*** but a record of the proceedings is kept.

The ***Mental Health Act*** sets out few other criteria or procedural guidelines for the Review Panel. Indeed, it does not state on what basis a panel should decide that a patient continues to be involuntarily detained. It is conceivable that a particular panel might decide a patient should be detained even though he or she was no longer certifiable under the ***Act***.[4] Concerns about the possible unfairness of such a finding, and of the wide discrepancy in procedures which panels could employ, led to the development of "Guidelines for Review Panels" in early 1992. These informal standards resulted from a consultative process sponsored by the Ministry of Health in which a number of agencies participated, including the Ombudsman.

The "Guidelines" have generally been adopted by the Review Panel chairs, and have brought an increased degree of procedural fairness and consistency to hearings. Consultation has continued between the chairs, legal representatives for patients, and Hospital administrators, in order to further refine hearing procedures. We believe the Guidelines have improved the degree of fairness in the Panel proceedings. The remaining concern at this time is that the "Guidelines" remain informal thereby having no legislative status, and no binding force. We believe it would be useful for these standards to be incorporated into regulations under the ***Mental Health Act,*** particularly for the benefit of future Review Panels.

We heard many people, other than patients, suggest that the Review Panels apply excessively narrow criteria for "protection of self or others", and thereby discharge too many patients. The Panels are thought by some to be an impediment to the treatment of patients in serious need, and to contribute to the number of seriously mentally ill people on city streets, without support or follow-up care.

[4] The Court in ***McCorkell*** stated that the Review Panel should apply the criteria set out in Section 20 of the Act to the determination of whether an involuntary patient should or should not continue to be detained.

Statistics kept by the Review Panel Office show a notable consistency. For the three calendar years 1990, 1991 and 1992, Panels discharged 18%, 25%, and 22% of the Riverview patients appearing before them at hearings. Hearings were held in less than half the instances in which patients applied; withdrawals by patients and decertifications by Hospital treatment personnel prior to hearing accounted for the bulk of applications that did not go to hearing.

Table 1:
RIVERVIEW REVIEW PANEL STATISTICS 1990-1992[5]

HOSPITAL(S)	APPLICATIONS FOR HEARINGS	HEARINGS CONVENED	PATIENTS DISCHARGED (% hearings convened)
Riverview 1990	486	198	36 (18%)
Rest of B.C. 1990	486[6]	78	18 (23%)
Riverview 1991	405	198	49 (25%)
Rest of B.C. 1991	246	95	33 (35%)
Riverview 1992	426	178	39 (22%)
Rest of B.C. 1992	327	105	42 (40%)

These numbers do not, by themselves, provide a great deal of information. Nevertheless, nothing in these figures suggests a systemic problem in Review Panel role and performance with respect to Riverview Hospital patients. Each hearing represents a disagreement between treatment staff and patient about the patient's certifiability. If the rate of discharges by the Review Panel was significantly higher than 20%, it might be assumed that there was a serious discrepancy between Hospital psychiatrists and Panel members about how to interpret the criteria for certification; a rate significantly lower than 20% might suggest that the Panels were serving no useful purpose in protecting individual rights.

Although the Review Panel's head office is located at Riverview Hospital, and the great majority of its hearings deal with Riverview patients, it does hold hearings at the psychiatric units of general hospitals around the Province. The Review Panel is an entity independent of Riverview

[5] Figures provided by the Review Panel Office.
[6] The figures available for 1990 did not separate Riverview hearing applications from the remainder of B.C. 486 represents total applications for hearings in B.C.

Hospital. This independence has not always been clear to patients, staff and families, because of the location of the Panel office and the joint administration of its budget and purchasing activities with those of the Hospital. In mid 1993 the Review Panel office moved from the East Lawn building to a stand-alone office on the grounds. Reinforcing the understanding of the Review Panel as a tribunal independent of Riverview Hospital will become particularly important as new tertiary care facilities are developed elsewhere in the Province.

RECOMMENDATIONS

4-1 That the "Guidelines for Review Panels" should be incorporated into Regulations under the ***Mental Health Act*** following the remaining consultation with interested parties including: present and former patients, families, lawyers experienced in acting for patients, community groups, representatives of Riverview Hospital, and professional groups involved in psychiatric care and treatment.

4-2 That the Ministry of Health work with the Review Panel chairpersons to develop a separate budget and purchasing arrangement for the Review Panels that would accurately reflect and reinforce its independence from Riverview or other psychiatric hospital facilities.

B. DEEMED CONSENT FOR TREATMENT

The ***Mental Health Act*** also limits patients' personal freedoms with respect to the right to consent to treatment. Common law recognizes the right of every individual to give or withhold consent to any form of medical treatment, including pharmacological therapy. The ***Act*** provides a way in which an involuntarily committed patient can be treated without consent, and even against the patient's express wish not to receive treatment. Section 25.2 of the ***Act*** reads:

"25.2 Where a person is detained in a Provincial mental health facility... treatment authorized by the director shall be deemed to be given with the consent of the person."

The effect of section 25.2 is that the director, or delegate, can give consent to treatment in place of the patient. The President of Riverview Hospital, an administrative official, is "director" for this purpose. One problem with section 25.2 is that "treatment" is not defined in the ***Act.*** It has been unclear for a long time whether the director can authorize medical treatment other than psychiatric treatment under this provision. A

consensus appears to have emerged in recent years, reflected in draft Riverview Hospital policy on consent, that only psychiatric treatment should be given without a patient's consent. We believe that should be decided and confirmed in any revision of the statute.

"Deemed consent" is arguably possible only where a patient is determined to be incapable of consenting to treatment. That is suggested by "Form 5", prescribed by Regulation under the ***Act.*** The Form requires that before the director of a facility can authorize treatment, a physician must determine that the patient "is incapable of appreciating the nature of treatment and/or his need for it, and is therefore incapable of giving consent." The assessment of capability to consent to treatment is a separate determination from certifiability. It is conceivable that a certified (i.e., involuntary) patient is nevertheless capable of consenting to, or refusing, treatment.

If a capable, involuntary patient refuses treatment, the director may have lawful authority to give a substituted consent to treatment under section 25.2. Implicitly or by policy, hospitals in the Province have assumed such authority exists. However, there is an argument that section 7 of the ***Canadian Charter of Rights and Freedoms,*** which guarantees "life, liberty, and security of the person", is infringed by section 25.2 because the latter purports to remove the right of a competent patient to consent, or refuse to consent, to medical treatment. That point has not yet been tested before the courts.

It is our understanding that the past practice in British Columbia has been for directors of mental health facilities and psychiatric units to authorize treatment for involuntary patients by completing Form 5 on a nearly automatic basis. This would not be done in cases where the patient willingly consented to treatment. We were pleased to note that Riverview has drafted guidelines for its physicians that focus on the need for an assessment of the patient's capability to consent to treatment. By doing so, however, the need to address the consequences of a "competent refuser" of treatment arises.

Draft Riverview policy on consent to treatment says that when an involuntary patient is assessed as capable to consent, the attending physician must forward an explanation and justification of the proposed treatment to the Vice-President of Medical and Academic Affairs/Clinical Director before deemed consent is given. The policy is silent on whether the physician's justification is subject to review by the Clinical Director, or is accepted as presented. Principles of fairness, including those imposed by the courts on administrative decision-makers where they are dealing with important rights or privileges of individuals, may require review by the

Clinical Director, and other procedural measures, such as giving the patient an opportunity to express her or his reasons for refusing the treatment.

An informal or voluntary patient is not subject to having consent given by the director. He or she must consent to treatment before it can be provided. That consent can be given for certain treatments, and not others, and it can be revoked at any time. Just as it is conceivable that an involuntary patient can be competent to give or withhold consent, it is conceivable that an informal patient may be incompetent. Riverview's present policy states that where an informal patient is incapable of giving consent, "it may be necessary for his status to be changed to that of an involuntary patient." It appears, in fact, that many patients, especially in the Geriatric Program, remained on involuntary status to facilitate treatment, even though they may not have been legally certified or certifiable. In addition, involuntary patients are not liable to pay a per diem charge for their inpatient care.[7]

Draft policy addresses this problem by saying that consent should be sought from a "substitute decision-maker" (SDM) under proposed guardianship law. Issues related to guardianship are discussed later in this chapter.

Electro-convulsive Therapy (ECT) and other treatments that might be termed invasive are not separately addressed by the ***Act***. Therefore, the same deemed consent provision applies. Riverview has recently adopted policy that requires a special procedure for obtaining consent for ECT or "investigational" treatments; it calls for obtaining a second medical opinion that ECT is the "indicated treatment", together with the documented consent of "involved family" (a term not defined). If the family refuses to consent, a "comprehensive justification" of ECT is to be forwarded to the Clinical Director. A deemed consent may nevertheless be given at that point.

[7] Regulations to the ***Mental Health Act*** provide a daily charge to be paid by an informal patient. Riverview Hospital policy provides that the *per diem* charge will not be levied until a patient has been in the Hospital on an informal basis for at least 90 days. Patients without income are not liable for this charge, so relatively few are affected. However, the *per diem* charge can impose hardship on spouses of patients. Individuals can apply to an assessment committee appointed by Cabinet for a reduction or cancellation of these fees under section 10 of the ***Act.***

There is no formal mechanism of appeal or review available to a patient (or family member) who objects to treatment without consent. This is not a matter subject to Review Panel jurisdiction. A patient might be able to bring legal action challenging the director's deemed consent under the ***Canadian Charter of Rights and Freedoms,*** or citing principles of administrative law. Such a case would raise a number of complex legal questions, and make representation by counsel highly advisable. The Mental Health Law Program has taken similar "test cases" on behalf of patients in the past, but to date, none have resulted in a full judicial consideration and determination of the issues involved.

In Chapter Six, we examine several informal avenues that may be available to patients who disagree with their treatment plan. It is important to recognize, however, that the involuntary mental patient faces a unique situation in which medical treatment may be beyond her or his legal control.

In this respect, British Columbia provides significantly fewer substantive and procedural rights to patients than is the case in several other provinces. For instance, in Saskatchewan, incompetence to consent to treatment is itself a criteria for involuntary detention. Involuntary patients can be treated without their consent, but by definition, any person competent to consent to treatment could not be detained in the first place (***Mental Health Services Act***, SS 1984-85-86, c.M-13.1). In Alberta, treatment cannot be given to a competent involuntary patient who refuses it, without order of a review panel (***Mental Health Act***, SA 1988, c. M-13.1). In Manitoba and Ontario, competent refusers cannot be treated. Patients incompetent to consent to treatment can be treated, but only if consent is given by a substitute decision-maker, or by authorization of a review panel (***Mental Health Act***, RSM 1987, c. M110; ***Mental Health Act***, RSO 1990, c. M.7). Patients can appeal competency assessments to the review panels in all these provinces. Review panel decisions on all matters can be appealed to the superior court in the respective province, which is not the case in British Columbia.

For over two years, the Ministry of Health has sponsored a consultative process directed at reforming the Province's mental health laws. The consultation has included Ministry officials and legal advisors, patient advocacy organizations, service providers, family-based organizations, representatives of health care professions, including psychiatrists, registered psychiatric nurses, and others. The impetus for the consultation came in part from concern that the ***Mental Health Act*** might be unconstitutional in several respects. Also, it reflected a desire to keep the legislation in step with developments in mental health services, including bringing services closer to the community.

At the time of writing, the consultation process is at an impasse. The controversial issues surrounding the criteria for certifying and detaining a person with a mental illness, and the power to treat that person without consent, have proven to be stumbling blocks. This is not surprising. In our investigation, we were repeatedly reminded of the strong feelings that surround these issues. Whereas patient advocacy groups believe that the individual choices, civil liberties and human rights of the mentally ill require much greater protection in law, treating professionals and family advocacy organizations feel with equal conviction that the law should not unnecessarily interfere with the "right" of ill persons to receive treatment, even if they do not want it. We hope these views, held in good faith as they are, can be reconciled to the greatest possible degree. We commend the efforts of those who have continued to work to this end.

We understand the concerns expressed by those groups and individuals who fear the consequences of placing procedural barriers in the way of treating persons with mental illness. Nevertheless, we believe it is inherently unfair for a system to permit individuals who are competent to decide whether or not to receive psychiatric treatment to be stripped of the power to make that decision by a purely administrative act (the hospital director's signing of a form). The insecurity which this unfairness creates for many persons with mental illness also poses its own barrier to their seeking treatment.

In this area, the issues are complex and require considerable attention from a number of sources. We strongly urge the Ministry of Health to renew a process of consultation to revise the ***Mental Health Act***. We believe there is a need for movement. Drawing together several issues raised in the preceding discussion, we make the following recommendations concerning needed revisions to the ***Act***.

RECOMMENDATIONS

4-3 That the Ministry of Health revitalize the consultative process for reform of the ***Mental Health Act*** and develop new or amended legislation with vigor. That attention be given to drafting a definition of "mental disorder" that is consistent with the ***Canadian Charter of Rights and Freedoms*** and Provincial Government guidelines on inclusive language in its references to disability, and by removing "mental retardation" from the definition.

4-4 That the Provincial Government propose to the Legislature amendments to the ***Mental Health Act*** for the purpose of introducing procedural fairness into decision-making concerning the provision of psychiatric services, including:

- independent review, by Review Panel or otherwise, of assessments of patient competency to consent to treatment;
- independent review, by Review Panel or otherwise, of decisions to provide psychiatric treatment without a patient's consent;
- clarification, possibly through a definition of "treatment", that any exceptional mechanisms for obtaining consent or approval for treatment of involuntary patients extend only to psychiatric treatment.

We think it is important that if the Review Panel was to assume jurisdiction over treatment and consent issues, appropriate resources should be devoted to this task to ensure a fair, accessible and expeditious process for patients. In this regard, the issue of adequate representation ought to be considered. Also, it would seem appropriate that the Review Panel have access to independent medical and psychiatric opinion to assist it in its work, that is, an assessment by a psychiatrist not affiliated with the detaining facility should be made available to patients on the initiative of the Review Panel.

RECOMMENDATION

4-5 That the Provincial Government should dedicate appropriate resources to ensure any expanded Review Panel jurisdiction can be carried out in a fair, accessible and expeditious manner.

One proposal for legislative reform deserves particular mention. The mental health consultation examined the possibility of incorporating a Bill or Charter of Patient Rights into mental health legislation. We support this initiative. The Riverview Hospital's Charter of Patient Rights has already been discussed. It represents a genuine attempt to place respect for

patients' and their interests at the centre of hospital service delivery for which the Hospital is responsible.

A legislated Charter of Patients' Rights would apply across mental health facilities. For that reason, it would likely not have the detail of a single hospital's policy, but set out standards of rights in key areas to be met in mental health service delivery settings throughout the Province.

RECOMMENDATION

4-6 That a Bill or Charter of Patient Rights be incorporated into British Columbia's mental health legislation to apply to all provincial mental health facilities and psychiatric units following consultation with consumers, mental health professionals and other interested parties.

C. INVOLUNTARY AND INFORMAL PATIENTS

For reasons of detention and consent to treatment, the distinction between involuntary and informal status is important. However, in many respects, the status does not make a great deal of difference to a patient's daily life at Riverview. Involuntary and informal patients live together in most Hospital wards. They receive the same services and engage in the same programs. Although informal patients have choices in law not strictly available to involuntary patients, they can be subject to many subtle pressures that reduce those choices. For instance, an informal patient who disagrees with a proposed course of treatment may be told that the Hospital has nothing else to offer, and that he or she should leave. On the other hand, the patient's status as informal could be quickly changed to involuntary if her or his choices appear to be creating a risk to self or others.

We are not suggesting that these pressures are brought to bear maliciously. The fact of living in a hospital setting imposes a set of realities that often makes legal rights less significant. For this reason, the balance of this Report does not distinguish between involuntary and informal patients when discussing non-legal advocacy and response mechanisms for Riverview Hospital patients. We believe these should be equally available to all patients regardless of status.

2. ADULT GUARDIANSHIP

An important area regarding patients' individual rights is guardianship, or as it has been termed in British Columbia in the past, "committeeship."

When an adult is deemed to be mentally incompetent to manage important areas of her or his personal life, the law provides ways in which another person can be appointed to make decisions on the individual's behalf.

Persons considered unable to speak for themselves may have another person, such as a spouse or relative, speak for them. This is called guardianship. Closely related to guardianship is the idea of "pre-planning" for incapability, in which a person while competent expresses their wishes should they later become deemed incompetent. Guardianship and pre-planning clearly have the potential to empower persons with mental illness, by expanding their ability to have a say in treatment decisions that may be necessary during periods of illness.

Guardianship, however, can also disempower a person. Since it involves the formal removal of legal decision-making authority from an adult, it can be a source of abuse and needs adequate monitoring. In the past, the combined impact of the committeeship provisions of the ***Patients Property Act*** RSBC 1979, c.313 and the deemed consent measures of the ***Mental Health Act*** have stripped patients of effective decision-making powers and of meaningful procedural protections. New guardianship legislation passed by the Provincial Legislature in July 1993 (but not yet in effect) is intended to redress the balance in favour of the vulnerable adult.

There are two kinds of guardianship in British Columbia at present: financial/legal guardianship of a person's property, and guardianship of the person, which includes health care decisions. Both will undergo substantial changes when the new legislation is proclaimed. We will review the present and proposed schemes for both financial and personal guardianship.

A. EXISTING GUARDIANSHIP LEGISLATION

■ Financial Guardianship

Traditionally, the most relevant aspect of guardianship for Riverview Hospital patients has been the process by which the Public Trustee becomes guardian ("committee") of a patient's estate. The ***Patients Property Act,*** the Provincial statute that has governed adult guardianship matters since the 1920s, provides an administrative procedure for having the Public Trustee appointed financial guardian or "committee" of patients in mental health facilities. Under sections 1 and 6 of the ***Act,*** the Public Trustee becomes committee of a patient simply when the Director of the facility signs a certificate stating that the person is incapable of managing her or his affairs because of mental infirmity. The Public Trustee cannot be appointed "committee" to make personal health care decisions by

certificate.

The legal significance of the signed certificate is striking; it has the immediate effect of removing the patient's decision-making authority around legal and financial matters, and putting it in the hands of the Public Trustee. In contrast, a private individual can be appointed financial guardian only by obtaining a court order.

The certificate procedure has the advantage of being fast. If a patient's personal assets are at risk during a period of illness, the Public Trustee can be quickly appointed to assume management. However, it also has serious disadvantages. The most important is the absence of any due process for a step with such sweeping consequences. In recognition of this problem, the Public Trustee and other government officials have developed an "Assessment Package" to guide mental health facilities in the preparation of certificates. The Package emphasizes that a full assessment of the patient's decision-making abilities and personal support network is necessary, and that the patient be notified and given an opportunity to object before an incapability certificate is completed. Riverview adopted the package as part of a revised policy in March 1993. A consequent drop in the number of certificates issued from Riverview seems to have occurred.

The Public Trustee advised that as of mid-1993, it acted as financial guardian for 171 Riverview patients. Approximately five new certificates were being received each month. Most of the Public Trustee's clients are patients in the Geriatric Psychiatry or Organic Brain Syndrome Programs.

We received complaints, particularly from Social Work staff in the Geriatric Program, that it was sometimes difficult to reach the Trust Officer at the Office of the Public Trustee responsible for a particular client's estate. We discussed this with Public Trustee officials, who agreed it might be useful to assign one staff person to receive and respond to all calls from Riverview and other residential care facilities. The Public Trustee has moved in recent years to providing a more active, personal service to its clients. We were interested to learn that Trust Officers are encouraged to visit clients at Riverview and participate in treatment team meetings discussing discharge plans. In effect, the Public Trustee now views its financial guardianship role as making it an advocate for the client, to be involved in planning decisions. This has occasionally created friction with Riverview Hospital staff, who see themselves having that primary responsibility while the person remains in the Hospital.

RECOMMENDATION

4-7 That the Office of the Public Trustee designate staff positions to

be responsible for receipt and processing of all financial requests regarding persons in residential care facilities in British Columbia including, but not restricted to, Riverview Hospital.

- **Guardianship of the Person**

The ***Patients Property Act*** has also governed guardianship of the person. Guardianship of the person includes decision-making powers over health care, where the adult resides, and many other matters affecting the individual's physical integrity and personal life. Under the ***Act***, guardianship has been an all-or-nothing affair. An appointed guardian assumes all of the adult's legal powers, leaving the adult without any. Unlike financial guardianship, the ***Act*** requires that any party, including the Public Trustee, seeking to become guardian of the person obtain a court order. Affidavits of two physicians swearing to the adult's mental incapability to manage himself or herself must be filed with the court.

Personal guardianship has been of little relevance to Riverview patients. Generally, the Public Trustee has not sought to become guardian of person, except in unusual circumstances. The Public Trustee is aware of only one instance when it obtained a court order regarding a Riverview patient. That occurred when Hospital physicians and immediate family could not agree on the need for, or risks of, Electro-convulsive Therapy treatment for an elderly patient. Few private individuals have become guardian of their relatives at Riverview, in part because of the time and expense involved in going to court. Lack of reliance on personal guardianship is also explained by other mechanisms available to a family and medical professionals under the ***Mental Health Act.***

B. NEW GUARDIANSHIP LEGISLATION

British Columbia's guardianship legislation has undergone a major review and overhaul. Four new pieces of legislation, the ***Representation Agreement Act***, the ***Health Care (Consent) and Care Facility (Admission) Act,*** the ***Public Guardian and Trustee Act***, and the ***Adult Guardianship Act,*** constitute a thorough reform of the Province's adult guardianship laws. In this report, we refer to all four ***Acts*** as the "guardianship legislation." As earlier stated, the new legislation has not yet come into effect. It is intended implementation will occur over the next several years.

The guardianship legislation will make several significant changes to financial and personal guardianship. These include the following:

- The Certificate process will no longer be available. Guardianship over financial matters, whether by the Public Trustee or a private individual, can be obtained only by court order.
- Incapability will no longer be an all or nothing affair. A court will be encouraged to grant limited decision-making powers with respect to certain specified financial and personal issues to a guardian, rather than sweeping plenary powers.
- Thorough assessments of decision-making needs and capacity will be required before a court order for anything other than temporary guardianship is made.
- The legislation provides a continuum of options of support for individuals who want or require help in making decisions about all aspects of their lives.
- The legislation allows for the greater involvement of supportive family and friends and the individual in the decision-making process.
- Measures in the new legislation allow individuals to pre-plan for times when they may be unable to make decisions, by appointing a "representative" who can make decisions on their behalf and in accordance with previously expressed wishes.

However:

- A provision in the ***Representation Agreement Act*** excludes persons involuntarily detained under the ***Mental Health Act*** from being able to plan to refuse, or have their chosen representative refuse, their admission to a Provincial mental health facility or psychiatric unit, or to refuse psychiatric treatment.
- Representative agreements and health care consent provisions will apply to the psychiatric admission and treatment of informal patients and to non-psychiatric health care provided to both involuntary and informal patients in psychiatric facilities. They do not govern psychiatric admission and treatment of involuntary patients.

■ Impact of the New Guardianship Legislation

There is an expectation that these changes will have a significant impact in mental health care. We are less confident of that impact with respect to the hospitalization and treatment of involuntary patients in psychiatric facilities. Our doubt arises from the fact that the Legislature expressly excluded involuntary patients from much of the pre-planning and temporary guardianship measures of the legislation.

The denial of access for involuntary patients to the pre-planning feature of

the new legislation is unfortunate. We understand this was done in order not to pre-empt discussion around revisions to the ***Mental Health Act***. We are also aware of the concerns of some groups that a person who becomes mentally ill to the point of being certified and detained might not be able to be treated if they had stated in a representation agreement that they refused all psychiatric treatment. Nevertheless, the ***Representation Agreement Act*** empowers individuals to plan for their health care needs during a future period of incapacity. The idea that the power to plan is available to everyone, except the person who later becomes involuntarily detained by reason of mental disorder, seems odd. In fact, it appears, on its face, to be discriminatory and to be a denial of the equal benefit of the law. This point is emphasized when one considers that the legislation authorizes planning to refuse life-saving medical care (for example, "living wills").

Pre-planning for episodes of mental illness is something to encourage, both because it respects the dignity and autonomy of the individual, and because it may often result in more appropriate treatment. We believe there should be an onus on treating professionals to respect a patient's wishes expressed when capable, and the views of a patient's chosen representative, unless clearly against therapeutic interests, despite the deemed consent provision of the ***Mental Health Act.***

We believe that the ***Mental Health Act*** should make advance health care planning, such as Representation Agreements, available to consumers of mental health services. An expanded Review Panel jurisdiction, earlier referred to, might then appropriately include an opportunity for review, initiated by the director of the hospital, of a patient's refusal of treatment under a representation Agreement. Pending revision of the ***Mental Health Act***, we recommend that the guardianship legislation be amended, prior to its proclamation, to provide mental patients with the same rights to plan for periods of illness as other health care consumers.

The legislation will have greater impact on the way treatment decisions are made by and for informal patients both in mental health facilities and in the community. There is a broad scope for developing strategies with and for the individual and to provide support and assistance during times of transition between facilities and the community.

The relationship between the law on consent to psychiatric treatment and the law on guardianship is complex. The intended benefits of the new guardianship legislation in British Columbia do not hide the fact that, at least for the time being, it adds to that complexity for some people.

One of the Principles set out at the beginning of this Report is that decision-making processes for responding to complaints must be easy to understand and accessible:

"8. Any decision-making process must be inclusive. The decision-making process must be accessible, understandable, responsive and expedient to those it affects including individual patients, patients as a collective, families, friends and advocates."

We are concerned this may not be the case with respect to the function of guardianship unless efforts are made to develop simplified practices and clear information guides. We are satisfied that health care professionals will also welcome such efforts.

RECOMMENDATIONS

4-8 That Mental Health Services, Riverview Hospital, and the Public Trustee, in consultation with the community, produce plain language guides describing the impact of guardianship legislation on mental health care and treatment, for patients and families; and that these authorities develop standard professional practices that respect the spirit and content of the legislation, and simplify its application.

4-9 That the Provincial Government propose to the Legislature amending the ***Mental Health Act*** to make advance health care planning available to all consumers of mental health services. Pending revision of the ***Act***, that the Provincial Government propose that the guardianship legislation be amended, prior to its proclamation, to extend the same rights to persons who may become involuntary patients as it provides to all other health care consumers.

3. CIVIL LEGAL PROCEEDINGS

Hospitalized individuals, like everyone else, have needs for legal service apart from their status under the ***Mental Health Act***. Many mothers admitted to Riverview, for instance, face problems related to custody of children, including the apprehension of their children by the Superintendent of Family and Child Services.[8] It is difficult to cope with such legal matters

[8] The ***Representation Agreement Act*** contains a provision that will allow pre-planning for child care arrangements by parents who anticipate a period of incapacity. Section 9(1) reads:
"In a representation agreement, an adult may also authorize his or her representative to....:

while a patient.

While the Mental Health Law Program[9] gives patients legal information and advice on an ***ad hoc*** basis, its mandate does not extend to general legal representation. We believe this need should be recognized and responded to. It might be met through a broadening of the Program's mandate and resources, or by otherwise making the services of the Legal Services Society more available to patients.

4. INFORMATION ON LEGAL RIGHTS

It is a leading principle of fairness that individuals be informed of their rights and remedies. Section 7 of the Regulations to the ***Mental Health Act*** requires a hospital to inform an involuntary patient, "immediately on admission... or as soon as the person is capable of comprehension", of the reasons for detention, the right to retain counsel, and of her or his recourses to Court and the Review Panel. At Riverview Hospital, this is usually the responsibility of the patient's primary nurse. This section also requires that a copy of the Regulation, and of section 21 of the ***Mental Health Act*** dealing with Review Panel jurisdiction, be "posted in a conspicuous place that is accessible to patients in a facility."

Since 1991, the Legal Services Society has funded the Mental Health Law Program to provide a "Rights Advisor", or Legal Information Counsellor to all newly admitted patients.[10] A trained paralegal reviews the patient's rights, and gives information on how the patient can apply for a Review Panel and representation at the hearing. This service is offered to all new admissions at Riverview Hospital, and the psychiatric units of five Lower Mainland general hospitals. It is not available elsewhere in the Province. We spoke to several former patients who said that having an independent person tell them of their rights as an involuntary patient made a huge difference to their sense of security and well being.

(f) make arrangements for the temporary care, education and financial support of
(i) the adult's minor children, and
(ii) any other persons who are cared for or supported by the adult"...

[9] The Mental Health Law Program is a non-profit legal service whose office is located in a cottage on the Riverview Hospital grounds. Its principle activity is providing legal representation to patients at Review Panel hearings. Please see further discussion on MHLP in Chapter Nine, under "Legal Advocacy."

[10] The LIC Program attempts to cover all renewals of certifications, as well as new admissions. Its ability to do so on a systematic basis may depend on increased funding.

CHAPTER FIVE
QUALITY OF LIFE

Chapter Five deals with the residential, or institutional, context of a patient's experience of Riverview Hospital. We have called it "Quality of Life", because that is what the present and former Riverview patients who spoke with us were most concerned about. In fact, patients had much more to tell us about Riverview as a lived, everyday experience than they did about the legal, treatment, or transitional (discharge planning) issues which are discussed in other Chapters, and issues that professionals involved in patients' lives likely consider more important.

"Quality of Life" serves as a recognition that patients in a psychiatric hospital are, first and foremost, living there. Even if a patient is in hospital for a limited time before returning to the community, he or she is living a life as a resident of the hospital. This is much more the case than it is for acute care hospitals, where "residence" is wholly secondary to illness and its time-specific treatment. All the concerns that people in the outside community have -- relationships with friends and family, money, work, leisure activities, privacy and personal development -- are concerns of Riverview Hospital patients as well. Yet all of these concerns are imbued with the demands, the intrusion, of an institutional setting. Life is itself "institutionalized." Speaking about life within the institution reminds everyone that quality of life within the Hospital should be maximized as far as is possible.

This Chapter covers a range of issues which affect a patient's quality of life at Riverview Hospital. They include admissions' policy and procedure, and several aspects of daily life, such as privacy, money, food services, relations between patients and staff, and personal security. We conclude with a detailed discussion of restraint measures used to control behaviour that poses a risk to self or others. We have included this discussion here rather than in Chapter Six, which deals with treatment issues, because the patients we spoke to experience restraint measures more as a feature of the Hospital environment than as therapy.

■ The Canadian Council on Health Services Accreditation Survey

It is important to understand the work of the Canadian Council on Health Services Accreditation (CCHSA)[11] and Riverview Hospital's accreditation status. The CCHSA conducts accreditation surveys of Canadian hospitals covering the whole range of hospital operations, including management, facilities, equipment and clinical practices. They provide a valuable yardstick to measure the performance of hospitals on Canada-wide standards of quality. The CCHSA uses a Mental Health (Psychiatric) Hospital Profile to assist it in surveying mental health facilities.

In 1991, Riverview Hospital received a full three-year accreditation from CCHSA, following one and two year accreditations in 1987 and 1989, respectively. Generally, CCHSA approved the management and direction of Riverview's clinical programs, while noting problems in providing adequate privacy to patients in the older buildings, the need to lessen controls on patient behaviour, and medical staff shortages. Accreditation involves an intensive staff effort of self-scrutiny and work with CCHSA surveyors. It serves the important purpose of ensuring that Riverview Hospital meets Canadian standards of patient care. Recommendations made by CCHSA in each accreditation period have led to improvements in several areas. In 1991, CCHSA surveyors met with the Patient Concerns Committee at Riverview, and incorporated several of its comments into its report. The survey for the next accreditation period will take place in October 1994.

[11] Formerly known as the Canadian Council on Health Facilities Accreditation (CCHFA). We would understand the change as denoting a broadening of the organization's mandate, such that it now surveys health services apart from hospitals.

1. ADMISSIONS

A patient's first impression of Riverview Hospital occurs on admission. Here, numerous events occur that will either welcome an incoming patient or make them feel alienated. The admissions' procedure sets the tone for a patient-centered philosophy that involves the patient in their treatment from the outset. In this section, we review the admissions policies and procedures -- who is admitted, on what basis, and how patients are admitted.

A. ADMISSIONS POLICY

Riverview Hospital has endeavoured in recent years to clearly define its role as a psychiatric, tertiary care facility. This has been achieved in part by imposing restrictions on admissions, supported by the Mental Health Services Division of the Ministry of Health.

Two important restrictions are based on:

- the nature of the patient's diagnosed mental disorder; and
- the need for referral from secondary care facilities.

■ Admission based on Diagnosis

Riverview's admission policy makes it clear that only patients with a primary diagnosis of one of the "classic" psychiatric disorders -- for example, schizophrenia, mood disorder, or bipolar disorder -- will be accepted for admission (with the exception of those admitted into the Organic Brain Syndrome program). Primary diagnoses of mental handicap or personality disorder will not support admission.

Policy PAT-005 states:

> *"i) Adult Division:*
> *All patients admitted to the Adult Division must be between the ages of 17 and 64 years and be suffering from a primary psychiatric diagnosis. Primary diagnoses of substance abuse, anti-social personality disorders and mental handicap (medically referred to as mental retardation) are not acceptable for admission to Riverview.*
>
> *ii) Geriatric Division:*
> *All patients admitted to the Geriatric Division must be 65 years or older and suffer from a major psychiatric disorder. Patients bearing a primary diagnosis of substance abuse will not be suitable for admission."*

The purpose of this restriction is to ensure that Riverview Hospital is engaged in active psychiatric treatment with its patients. Contemporary psychiatric treatment is, first and foremost, pharmacological in nature. Disorders such as anti-social or borderline personality are not presently amenable to medications. Instead, they require intensive behavioral programs which Riverview does not provide.

"If Riverview refuses to admit these individuals, where else can they obtain treatment?"
A parent of a patient

We heard complaints about this admission restriction. Several people said that Riverview's policy of excluding individuals diagnosed with personality disorders amounted to refusing to take difficult patients who pose a greater challenge to ward nursing staff. A mental health professional said that diagnoses in mental health are notoriously uncertain, and that "personality disorder" is a relatively new category that serves as a catch-all for many troublesome cases; he believed it was too easily used as a means to exclude.

The question posed, is a complex one involving treatment modalities and allocation of resources. We heard strong views on the other side of the issue from professionals within and outside Riverview Hospital. They believe that persons with a primary diagnosis of personality disorder are generally not certifiable, and should not be hospitalized. Out-patient programs involving intensive behavioral therapy have proved more successful for this group. In late 1993, a Task Force on Personality Disorder initiated by the Hospital, brought together professionals from a number of service agencies. It reported that "long-term hospitalization is rarely indicated" and the "role of Riverview should be negligible."

- **Admission based on Referral from Acute Care Hospitals**

Admissions policy states that all patients must be referred from a general hospital. Riverview Hospital no longer admits patients directly from the community, or on referral from private physicians. An exception to this general rule exists for admissions to the Geriatric Program.

This change in policy was encouraged by the Mental Health Services Division. Mental Health Services' and Riverview's administration believed this restriction was necessary if adequate secondary care by psychiatric units in the Province's general hospitals was going to be provided. We were told it had been too easy for general hospitals to avoid developing acute psychiatric care programs for their regions and neighbourhoods, so long as Riverview continued to accept admissions directly from the community, often by-passing the local general hospital.

Community mental health administrators and staff expressed concern that the strict application of Riverview's "referral" policy is detrimental for some discharged patients who have to be re-hospitalized. They believe that the policy can add to the disorientation and fear experienced by discharged persons in an acute phase of mental illness.

Riverview discharges most patients by way of a two-week "visit leave." This means that the person formally remains a patient of Riverview for the first two weeks away from the Hospital. Should their mental health deteriorate in that period, they can be brought back to the ward they left at Riverview without going through admission. At the end of two weeks, if the person has remained in the community, a full discharge is completed. If the patient needs to return to Riverview, it must be done as a new admission, by referral from a general hospital.

An exception has been made for patients being discharged from the Continuing Treatment Program as part of the bed closure process. Those patients have their home ward beds held for up to six months following discharge.

Several people told us that two weeks is too short a period, because an early decompensation in mental condition rarely occurs that quickly. They are concerned that the "shuffle" involved in being admitted into emergency psychiatric care in a general hospital before being re-admitted to Riverview causes unnecessary harm. This is particularly so for patients who were at Riverview for an extended time prior to discharge. In the view of some community mental health workers, Riverview "owes" a direct re-admission to such patients. At best, the two week period appears arbitrary because it fails to assess each person discharged on the basis of their individual needs.

RECOMMENDATION

5-1 That Riverview Hospital's policy on admissions be made more flexible, to permit re-admission of patients who have been recently and formally discharged or who have been long-term Riverview patients, without having to be re-admitted through psychiatric units in general hospitals.

B. THE PROCESS OF ADMISSION

Admissions to Riverview are approved before a patient arrives at the Hospital. Patients admitted to the Adult Division do so on referral from the psychiatric unit of an acute care hospital. This means that most admissions to Riverview Hospital are actually transfers under section 29 of the ***Mental Health Act,*** rather than new admissions under section 20. Patients coming into the Geriatric Division are usually referred by their general practitioner, and have been living in their home or in a nursing home. In the case of geriatric admissions, an admitting nurse from Riverview conducts an on-site visit to the home or facility to meet the person in advance.

"Arriving at Riverview was like falling off the edge of the world. None of my friends knew where I was and I had no money to make a phone call."

A patient

In an average month there are 15 admissions to the Geriatric Division and 60 to the Adult Division. The Admissions Department is responsible for the completion of necessary paperwork and assigning the patient to a ward. Almost all patients admitted to Riverview are involuntary at the time of admission. Two certificates completed by physicians at the referring hospital or facility accompany arriving patients. These certificates state the grounds for committal under the ***Mental Health Act***. Admissions staff check the certificates for completeness, and the Admitting physician reviews their content. Informal (voluntary) patients are required to sign a Request for Admission form.

"The first admission to the Hospital for psychiatric treatment is a shock to their whole system."

Member of a community group

Admissions staff send out various notices once a patient has been admitted to Riverview. Pursuant to section 28 of the ***Mental Health Act,*** a letter is sent to the patient's next-of-kin advising that the patient has been admitted to the Hospital. This letter describes the patient's and relative's rights to seek review of the committal. If next-of-kin is unknown, the notice must go to the Public Trustee. However, section 28 applies only to admissions under sections 19 and 20 of the ***Act,*** and since most admissions to Riverview Hospital are done pursuant to section 29, the Hospital does not in those cases have authority to notify families of an admission without the patient's consent. The responsibility to send the section 28 notice lies with the referring hospital that originally admitted the patient. Admissions staff also notify the Mental Health Law Program (MHLP), the law office located on the Riverview grounds, of every new admission. Another letter is sent to the patient's family physician (if known), giving the name of the attending physician at Riverview.

"The first time at Riverview I remembered I was groggy and had spoken to a psychiatrist in the middle of the night. I'd had a physical check-up and nothing else. There was no information regarding visitors or what involuntary committal meant. I found out most of these things on my own."

A patient

Most patients are brought to Riverview by the Provincial ambulance service. That is a separate service, and Riverview has no control over when a patient arrives. Ambulance attendants wait with the patient while paperwork is completed. A Hospital escort accompanies the patient to her or his assigned ward. Patients in the Adult Division are usually admitted to one of five wards in the Acute Assessment and Treatment Program in Centre Lawn.

Patients receive a bath, and are given pajamas to wear until they are seen by the ward physician for a physical examination. This is supposed to take place within two hours of arrival. Patients are placed on "special attention" by nursing staff, which means staff monitor the patient regularly and make note of their condition every 15 minutes. "Constant attention", (unbroken observation of the patient) may be required if their behaviour is particularly unpredictable. The patient is assessed by the attending ward psychiatrist within 24 hours of arrival, who may prescribe medications, change the level of observation, and assess the appropriate level of grounds' privileges.

Orientation to the ward and the Hospital is important in order to minimize the confusion or anxiety a patient may have on arrival. A nurse on the ward introduces the patient to other staff and patients on the ward, and gives a tour of the ward. The patient meets with her or his primary nurse, who has the responsibility to follow the patient's case throughout their stay on the ward, and be the liaison between the patient and the treatment team. Each patient is provided with a copy of Riverview Hospital Information for Patients brochure that outlines generally the services provided at the Hospital, legal rights and other introductory information.

Regulations under the ***Mental Health Act*** require that a newly admitted patient be informed immediately "or as soon as the person is capable of comprehension" of the reasons for detention, the right to retain and instruct counsel, and rights to have detention reviewed by a Review Panel or the Courts. This task is assumed by a member of the treatment team. In addition, the patient will be visited within 48 hours of admission by a para-legal from the Mental Health Law Program who reviews these rights with the patient. Financial issues are discussed with the patient by the ward social worker.

Riverview has recently instituted the practice of having the social worker at the Family Resource Centre send out a package of information to the patient's family shortly after admission. There are efforts underway to consolidate all of the information that is sent out to families. A letter explaining the per diem charge for voluntary patients is included.

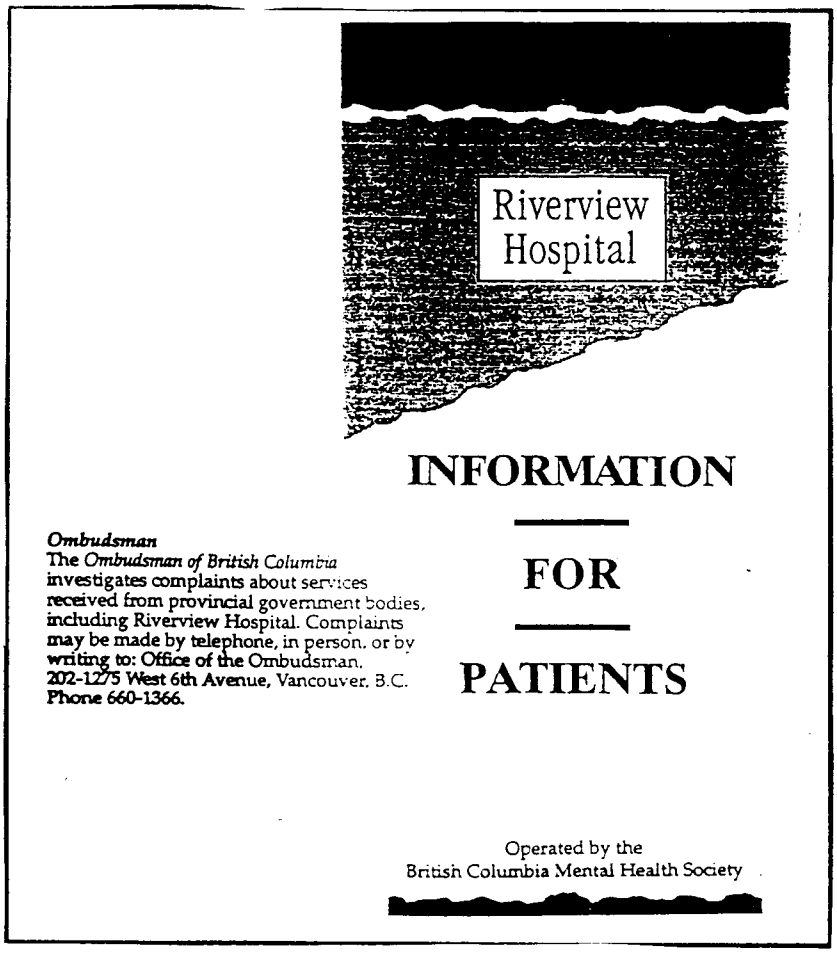
"Only if a doctor from the unit follows up on a patient who has gone to Riverview will information be provided. It would be most useful for some automatic reporting back to be made, especially a discharge note."

General hospital psychiatrist

The primary concerns regarding admissions relate to patients' lack of knowledge about the hospital, the programs available and what lay ahead for them. Comments from patients about the admission process focused on lack of information provided, insufficient orientation to the hospital and staff and feelings of alienation. Other comments from individuals outside the hospital noted a need for more information exchange between Riverview Hospital and the originating acute care hospital, mental health center and personal physician.

RECOMMENDATION

5-2 That protocols and policies be developed by the Ministry of Health, Riverview Hospital, Mental Health Services, the Greater Vancouver Mental Health Society, and the governing bodies of acute care hospitals with psychiatric or referring emergency units, to promote the regular sharing of progress and discharge notes with respect to individual patients between the referring and treating agencies, while respecting patients' rights of confidentiality.



2. DAILY LIFE

In this section, we address several issues that affect patients' lives on a daily basis. We touch on them to show the nature of concerns which exist, and to acknowledge their importance. It is these issues, which fall in an area of administrative decision-making, that form the core of patient advocacy. The Hospital needs to implement a complaints-handling and response mechanism in order to deal with these issues effectively, a task now being undertaken (see Chapter Eight).

A. BUILDINGS AND WARDS

It is difficult to describe a "typical ward" at Riverview. All told, the five Programs comprise 32 wards in at least eight buildings which vary in age and design. The majority of patients in the Adult Division reside in East Lawn and Centre Lawn, two large five-story buildings containing 11 and five wards, respectively. Both buildings have undergone renovations within the past four years.

"I was pleased with the care my son received at Riverview. The grounds are peaceful and beautiful, and afford the opportunity for lovely walks. The patients deserve to live in surroundings like that."
A parent

Wards in East Lawn and Centre Lawn house up to 25 patients each. Patients share rooms with up to five persons of the same sex, although each ward has two or three single rooms. Most wards integrate the sexes, although there are locked male and female wards in East Lawn. There is a separate shower/bathing area that has three tub/shower units and a separate bathroom on each ward. Privacy is at a premium.

Each ward has a central nursing station, a dispensary, a treatment room, a common or day room, and a lounge/games room where smoking is allowed. A telephone is located on each ward for patient use. In the Fall of 1993 a longstanding request of the Patient Empowerment Society for free local telephone service to replace pay phones was fulfilled.

B. PRIVACY

One of the most frequent complaints of patients at Riverview Hospital is a lack of privacy. With renovations to the Centre and East Lawn buildings over the past four years, and the closing of Crease Clinic in 1992, one no longer sees a twenty person dormitory. Still, most patients share sleeping quarters with five to seven other people. Only in the Community Psychiatry wards, Fernwood and Brookside, does every patient have their own room. During the day, patients on a locked ward or who are restricted to their ward, must share a large day room. With the exception of rooms used for seclusion, patients have no indoor places where they can be assured of being by themselves.

The privacy issue arises most acutely with respect to sexual activity. To its credit, Riverview Hospital has recently addressed this matter directly. Following a survey of staff and patients, and the forming of a staff-led Task Force to make recommendations, the Board of BCMHS adopted in July 1993 a "Patient Sexuality Policy." This is believed to be the first such policy in Canada. The Policy, among other things, provides a process whereby patients can get access to a private room for purposes of intimacy. It sets out a number of safeguards intended to protect individuals who may be vulnerable, or prone to unsafe conduct. It remains to be seen whether the Policy will serve to restore dignity or any sense of normalcy to this area of personal life for patients. For one thing, present facilities do not have privacy rooms. The first pilot privacy suite will be available in June 1994, on a trial basis by agreement with the PES. Still, with this Policy, Riverview has made a serious attempt to address a sensitive subject that previously was not even spoken about.

In the past, a barrier to providing more privacy has been an argument that it compromises security. In order to emphasize inclusion, it will be essential to ensure privacy. The Hospital's Charter of Patient Rights includes a "right to privacy." It is hoped this will help provide and expand privacy opportunities.

RECOMMENDATION

5-3 That in the design of any renovated or new hospital facilities on the Riverview site, the principle of maximizing privacy for individual patients be adopted, including the use of single rooms wherever feasible. This factor ought to be considered by the Ministry of Health in planning regional mental health care.

C. ACCESSIBILITY

Primarily due to the age of its buildings, Riverview Hospital is not fully accessible for persons with mobility impairments. Level entrances appear to exist for all patient care areas, but second floors in some buildings can be reached only by stairs. Access has been improvised in various places. The grounds are large and hilly. Curb cuts are scarce on the streets running through the grounds. It would be difficult for patients or staff using manual wheelchairs to get around the buildings or grounds without assistance. One of the main cafeterias for staff, volunteers, patients and visitors is totally inaccessible. As is the case in extended care facilities, modern mobility aids, such as motorized wheelchairs, are not generally available to patients.

The Hospital maintains a list of staff persons to act as interpreters for patients who are not comfortable speaking English. If a staff interpreter is not available, the Hospital will obtain the services of an interpreter from the community. New Hospital policy on interpreting makes reference to American Sign Language being used for deaf and hearing impaired patients.

RECOMMENDATION

5-4 That the design of any new hospital facilities or renovations undertaken on the Riverview site incorporates a maximum degree of accessibility.

D. FOOD SERVICES

"The food was too good! I gained weight..."

A patient

Patients receive three meals a day in dining areas that are on or separate from the ward. The food preparation system used at Riverview is known as "cook/chill", and was adopted three years ago. Meals are centrally prepared in Valleyview Pavilion and quick chilled. They are stored in refrigerators for two or three days. Bulk meals are transported in refrigerated trucks to the East Lawn kitchen where they are placed on trays while kept under controlled cool temperatures. The cold trays are delivered to the dining rooms, where heating equipment brings the meals to serving temperature within 45 minutes.

"The food is gross... I would like a vending machine for drinks and snacks on the ward. There is one, but it's for staff use only."

A patient

Clinical dietitians visit the dining rooms at mealtimes to check with patients about menus and to perform quality control. The Hospital operates on a four-week menu cycle with allowances for individual choices and special diets. There is a small kitchen area on wards for making hot drinks and snacks. On most wards this area is more available to staff than patients. We did not receive many complaints from patients about food quality, but a number of staff and family members said that meals varied in quality and appearance, and often seemed to fall below acceptable standards. Riverview itself commissioned two consultants reports in 1993 on the cook/chill system, which uncovered a number of deficiencies and made several recommendations, the cost implications of which are being studied.

RECOMMENDATION

5-5 That Riverview Hospital clarify and publicize its policy that kitchen areas on wards are for the use and benefit of the patients, not the staff.

E. CLOTHING

Riverview patients wear everyday clothing unless subject to a restriction to pajamas. If on admission the patient needs clothes, the Hospital has a stock of clothing from which the patient can choose. Shoes, socks and underwear are provided by the Hospital for all patients. The Volunteer Service operates the Apparel Shop on the grounds. A patient needing a particular item can bring a requisition from the home ward, and select from the donated clothing in the Shop at no charge. A patient may, of course, buy clothes in the community, and relatives often bring clothing for patients. The combination of poverty and second-hand clothing that may not always fit contributes to a "look" that is part of the stigmatizing of mental illness.

"They should get rid of the 'Thrift' store clothes and institutional haircuts that label patients as just that -- psychiatric patients."
A Family member

Patients are encouraged to keep with them only those items that are necessary for their use in the Hospital. Patients' valuables are stored in a secure area of the Hospital. An inventory is made at the time of admission and is retained on the patient's chart. Every patient has a bedside locker for personal belongings and clothes. However, insecurity about personal possessions and clothing abounds. Relatives are often frustrated to find that new items of clothing purchased by them for a patient go missing soon after being given. This is a difficult issue for the Hospital. Too many controls on what patients can do with their property would intrude on their personal choices and freedom.

RECOMMENDATION

5-6 That Riverview Hospital consult with the Patient Empowerment Society about ways to provide clothing to patients that are appropriate.

F. COMFORTS ALLOWANCE

Poverty and mental illness too often go hand in hand. Most Riverview patients (i.e., those who are eligible for income assistance because they have no income or appreciable assets) receive only a comforts allowance of $82 per month. Poverty is one of the predominant factors of everyday life at Riverview. When one considers that $82 is all the money available to many patients for every discretionary expense they have, including additional food and clothing, entertainment, gifts, etc., its inadequacy is readily apparent.

Comforts allowances are automatically deposited into an account administered by the Hospital. Patients' income from other sources is deposited in a separate trust account. A somewhat paternalistic approach to patient accounts has been taken over the years. Patients have access to their funds in these accounts by taking requisitions made up by ward nursing staff to the accounts' office. Therefore, nurses are involved in budgeting for every patient. The practice was recently instituted of writing the balance in the account on the bottom of every requisition form. Prior to that, patients could receive a statement of their account only by asking a nurse to make that request on their behalf. The accounts do not pay interest and no service fees are charged. Patients are encouraged to use the on-site Credit Union for banking purposes if their assets are $500 or more, but few are in that position.

G. VOCATIONAL AND OTHER SERVICES

"The patient library was a joke. I used to go in and photocopy stuff from the medical journals in the staff library and then hide it because staff didn't think that was 'good reading' for a patient. The books in the patients' library were Nancy Drew or very old."

A patient

A complaint we heard from many patients and family members is that there is not enough for patients to do during the day. Riverview Hospital has a recreation and activity centre in Pennington Hall ("Penn Hall"), at the west end of the grounds, which is popular with patients. Thanks in large part to the Patient Empowerment Society, Penn Hall now stays open on weekends. Among other services available to patients, the Hospital has a library and a Tuck Shop which sells fresh sandwiches, snacks, tobacco and toiletries.

The Hospital offers vocational programs. Newly arrived patients are first assigned chores on the ward, often at ward meetings. Depending on their progress, the treatment team may make a referral to Vocational Services. A vocational worker will meet with the patient to discuss possible on-site work placements. Approximately one-half of Hospital patients are involved in such programs, for periods up to five hours each day. They receive "incentive payments" which fall well below Provincial minimum wage standards. The present scale for incentive payments runs from 20 cents to $1.00 an hour.

We believe that one way to alleviate the poverty that patients experience would be to increase the incentive payment scale. It is also important that opportunities to receive incentive payments expand to more patients. One problem in expanding the amount of extra income that patients would receive through vocational activity is that, as with GAIN, generally income over a certain amount is deducted from the comforts allowance. We think that a further exemption should be created for incentive payments for inpatient vocational "work" so patients could keep the whole extra amount paid to them.

RECOMMENDATION

5-7 That the Ministry of Health and Riverview Hospital expand vocational program opportunities, and in particular, opportunities that attract incentive payments, and that the payment scale for vocational work be significantly increased. The Ministry of Social Services should exempt incentive payments paid by in-patient vocational programs from being deducted from the comforts allowance.

H. TOBACCO USE

"The prevalence of smoking amongst the hospital patients and the ever increasing price means all of my son's money goes to buy cigarettes."
Parent of a patient

Another predominant factor of Riverview life related to poverty is tobacco. A high percentage of patients smoke, many of them heavily. Given the cost of tobacco, many patients spend most or all of their money on cigarettes. An underground economy between patients thrives based on this commodity. Talk about tobacco -- who has it, how much is being stored for a patient at the nursing station, etc. -- is ever present.

We are aware that some patients and family members would like to see the cost of tobacco subsidized, or even provided to patients at no cost, as is apparently done in Saskatchewan. We are reluctant to support that approach because of its obvious health implications. Instead, we would prefer to see the poverty issue addressed directly through an increase in the incentive payment, as recommended. This places the choice rightfully in the hands of the individual. At the same time, we support those patients, staff and families who wish to see more programming to help patients stop smoking, and to provide smoke-free facilities and living units for patients who do not smoke.

RECOMMENDATION

5-8 That the Ministry of Health and Riverview Hospital work together to develop effective education programs that assist interested patients to reduce or stop their smoking; that renovations to or redevelopment of Riverview Hospital should incorporate smoke-free living units for patients who do not smoke.

I. STAFF/PATIENT RELATIONS

"I observed staff speaking to each other without acknowledging that a patient was in their midst. The effect was to treat patients as nonentities, not even as human beings. Common courtesies were not respected and patients were rarely called by their names."
Parent of a Patient

The interaction between patients and staff persons is a crucial aspect of everyday life at Riverview Hospital. Staff persons, particularly nurses working in direct patient care on the wards, have an extraordinary influence on the health and well-being of patients. We met many staff from all parts of the Hospital who impressed us with their sincerity and professional dedication. There is a great deal of affection and concern on the part of most staff for those they work for and many staff who feel triumph in watching a patient progress and leave the Hospital.

Patients and family members with whom we spoke recognized this quality in many Riverview staff. Almost all of them told us of nurses, health care workers or others, who made a positive difference in peoples' lives.

"Recently, I visited a ward and was pleased to find it light years removed from my earlier experiences. The staff were enthusiastically interacting with patients and I sensed a vibrancy amongst staff that I had not seen before."
A relative of a patient

At the same time, however, we heard consistent criticism of an attitude toward patients taken by some staff members. Both patients and family members frequently mentioned the following tendencies: a reluctance to interact with patients, such that on certain wards or shifts, staff seem to spend most of their time in the nursing stations; talking about a patient as if the patient was not there; speaking to patients in an abrupt or directive manner, rather than in a conversational tone; overreacting to situations perceived to raise security concerns; and monopolizing amenities intended for the benefit of patients, such as television, newspapers and kitchen facilities.

To generalize about such an attitude or its causes would be unfair. We do not think it applies to the majority of Riverview Hospital staff. To the extent it exists, it would appear to be an outgrowth of institutionalization. Hierarchical decision-making in a large organization, limited exposure to how services are provided in the community, regimented daily routines, the limited capacity of patients to speak for themselves due both to illness, treatment and law, and the way in which wards are administered for expediency rather than patient-centeredness may all contribute to problematic attitudes. We did note that areas of the Hospital more closely involved in active treatment and preparing patients for a return to the community received less criticism of this kind.

It would take a much more extensive investigation than we were able to undertake to address this subject with the appropriate depth and sensitivity. We believe that the expansion of opportunities for patients to voice their complaints as individuals and in groups and to be supported by advocates, as this Report recommends, can be part of the solution to this problem. This will also be welcomed by the many Riverview Hospital staff who already apply the highest professional and ethical standards to their work with patients.

3. PERSONAL SECURITY AND INCIDENT INVESTIGATIONS

Personal security is a central quality of life issue. Particular challenges are posed in a psychiatric hospital setting to the security of patients and staff alike. We do not mean to suggest by this that Riverview Hospital is a dangerous place. That unfortunate stereotype is far from the truth. Life at Riverview is, in general, remarkably secure and calm. However, incidents can and do occur. Some may be directed by patients against other patients, or patients against staff. In a psychiatric hospital, where there is an imbalance of power between staff and patients, there is also the potential for abuse by staff. Our concern in looking at the issue is to ensure that fair and accessible processes are in place for patients to complain about threats to their personal security.

A. ASSAULT BY A PATIENT

Mental illness on occasion manifests itself in what is or appears to be aggressive behaviour. This, combined with a lack of privacy and the close quarters in which patients live, can create tensions. The skill and dedication of Riverview staff members who handle such situations, succeed in reducing tensions and risks for all concerned. In addition to steps taken within the Hospital to prevent and intervene in such incidents, there is a question of when police should be involved.

Riverview Hospital falls within the area policed by the Coquitlam Detachment of the RCMP. In the past it has been difficult to get the RCMP to investigate and to have charges laid with respect to alleged assaults, whether on patients or staff members. There was an assumption that if the suspect or victim was a patient with a mental illness, a conviction could likely never be obtained. Members of the public often hold the view that it is inappropriate to charge a mental patient with a criminal offense. By not charging a patient, however, the victim is denied one of the law's principle protections. A wholesale denial of responsibility of mental patients for their actions devalues both victim and perpetrator. We believe protocols should be in place so that police will attend and investigate incidents of assault on Hospital grounds and, where appropriate, ask Crown Counsel to approve charges.

RECOMMENDATION

5-9 That Riverview Hospital develop a protocol with the local RCMP detachment and Crown Counsel with the goal of providing clear guidelines for police, as to when to attend and investigate and for Crown Counsel, when to prosecute allegations of criminal behaviour by patients.

B. PATIENT ABUSE BY STAFF

We believe it is incumbent on any institutional facility which detains or houses vulnerable people to have processes in place that ensure a quick and thorough investigation of alleged acts of abuse of residents by staff members.

Riverview has a "Patient Abuse by Staff" Policy CRI-015, and has just completed a revision of the policy. A few of its key features are as follows. Every report of alleged abuse by staff, whether the report is made by a patient, staff member, or other person, is subject to internal investigation. Staff members are under a duty to report any suspected patient abuse. The investigation is carried out by a personnel officer from the Human Resources Department, together with a manager from a department other than where the allegation arose. The investigation report must be forwarded to the President of Riverview within two weeks, or an explanation provided for any delay. The patient and other parties are advised by the investigators of the right to request an investigation by the Ombudsman. From the outset, the President may direct that a report be made to the RCMP.

The policy does not say that patients will be advised of their right to contact the RCMP. The policy is silent on whether staff alleged to have abused a patient would be moved from the ward or from direct contact with the patient pending outcome of the investigation. It may be important to a patient's sense of security that this occur. Nevertheless, we are reluctant to suggest that moving the staff member should be an automatic consequence of an allegation. Rather, we believe this is a matter that deserves serious consideration at the outset of every investigation and that a policy be put in place. The "appropriate Vice President" and the Vice President, Human and Material Resources, should decide this question in each particular case.

An important aspect of the new policy is its broadened definition of "abuse." The definition refers to acts or omissions causing or likely to cause physical or emotional harm. Examples include acts or threats of reprisal directed at a patient who has utilized complaint and review procedures.

This appears to be a well-crafted policy. Investigations carried out to date under its mandate have been thorough. We believe it will help create confidence in the ability of the Hospital to deal seriously with complaints of this kind.

We were surprised to find that relatives and friends of Riverview Hospital patients did not know that the Hospital had a formal process for reporting and investigating patient abuse complaints. This should be made known through orientation materials, in particular, be referred to in the orientation package sent out by the social worker at the Family Resource Centre.

RECOMMENDATIONS

5-10 That the "Patient Abuse by Staff" policy include a statement that patients who are the victims of alleged abuse which may constitute a criminal offense be advised at the outset of an internal investigation of their right to contact the RCMP.

5-11 That the "Patient Abuse by Staff" policy direct the appropriate Vice-President and the Vice President, Human and Material Resources, in consultation, or other senior administrative personnel, to consider at the outset of every investigation whether the staff member, against whom an allegation has been made, should be removed from any direct contact with the patient involved or patients generally pending outcome of the investigation.

5-12 That information about the incident investigation policy with respect to allegations of patient abuse by staff members be included in orientation materials made available to patients and their families.

4. RESTRAINT

One of the most consistent themes we heard in our interviews with present and former Riverview patients is that an atmosphere of compulsion is prevalent on many wards. This concern is shared by relatives, and several community organizations.

There are several methods used at Riverview to "control" or "direct" patient behaviour including:

- seclusion,
- physical and mechanical restraints,
- chemical restraints,
- restrictions on movement within and outside the Hospital governed by grounds privileges, and
- clothing restrictions (i.e., restriction to pajamas).

Placing our discussion of restraint measures in a Chapter on quality of life issues, rather in the next Chapter which deals with treatment issues, may be controversial. We understand that in one sense, restraint measures should be placed in a treatment context. That is, in a treating facility like Riverview Hospital, any use of restraint should be assessed and approved within the strict bounds of clinical judgment. We believe that Riverview is moving its policy on restraints in that direction, particularly in its newly adopted seclusion policy, discussed below. For now, there are two reasons why we include our review of restraint measures in our Chapter on quality of life:

(1) restraint is most often not a form of active treatment; and
(2) patients have experienced restraint as punishment more than as part of their overall treatment.

A number of methods of controlling patient behaviour are experienced by many patients as forms of discipline or punishment. Patients feel that restraint is decided upon arbitrarily, without an opportunity for them to complain or appeal. In this section, we review current Riverview policy and practice in these areas and discuss ways to introduce a greater degree of fairness in their application.

The Riverview Hospital's Charter of Patient Rights speaks to a basic right in this area:

> *Part II, # 11:*
>
> *"The right to be free from chemical and physical restraint, except in an emergency where it is necessary to protect the patient from injury to self or others. The physician must have authorized this restraint for a specified and limited period of time."*

This right serves as a general framework limiting the use of restraint measures at Riverview Hospital.

A. LEGAL AUTHORITY FOR RESTRAINT METHODS

Restraining an individual's freedom of movement is unlawful in Canada, unless there is legal authority to do so. In Chapter Four we discussed the British Columbia ***Mental Health Act*** provisions which authorize the detention of "mentally disordered persons" in psychiatric facilities. The legal authority to employ forms of restraint within these facilities may be partly inferred from the power to detain. In addition, the ***Act*** states in section 26:

> *"26. Every patient detained in the Provincial mental health facility is, during detention, subject to the direction and discipline of the director and the members of the staff of the Provincial mental health facility authorized in that behalf by the director."*

This leaves unanswered the question of the authority for employing forms of restraint with informal (i.e., voluntary) patients, who are not "detained" in hospital, but are there of their own accord. Riverview Hospital officials agreed with us that there is an apparent contradiction in using restraint with informal patients. They believe it is an infrequent occurrence, although it does happen. It may be that the only valid authority for restraining the informal patient is her or his consent.[12]

The ***Mental Health Act*** does not otherwise speak of restraint measures, and so gives no standards to be met by psychiatric facilities in this area. This is unlike the Ontario legislation, which defines "restraint" as:

[12] For a useful discussion of the issue of legal authority for restraint measures used in psychiatric facilities, see D. Waring; "Use of Restraints in Ontario Psychiatric Hospitals"; 1991; 7 Journal of Law and Social Policy 251. Also see the Supreme Court of Canada decision in ***Wellesley Hospital v Lawson*** (1977), 76 DLR (3d) 688.

> *"(to) place under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient."*[13]

The "minimal use" standard is the safeguard employed by that legislation.

The ***Health Care (Consent) and Care Facility (Admission) Act***, part of the package of adult guardianship legislation passed by the Provincial Legislature in July 1993, but not yet in force, sets out both the authority for, and limits on, restraints in care facilities. This statute does not apply to Riverview or psychiatric units in acute care hospitals, but it is instructive. When proclaimed, it will apply to licensed care facilities throughout the Province, housing residents whose behaviour poses no less a risk to themselves or others than that of Riverview patients. The ***Act*** makes it clear that restraint is an exceptional measure, to be used only as a last resort, in a minimal fashion, and (generally) only if agreed to by a representative or substitute decision-maker. Further, the decision to employ restraint is subject to review by the new Health Care and Care Facility Review Board. This presents another example of where the proposed benefits under the guardianship legislation are not available to Riverview patients.

Currently in British Columbia, it remains the responsibility of each psychiatric facility to establish its own policies and procedures with respect to restraint measures. The safeguards in the ***Health Care (Consent)*** statute should serve as a guide for these policies. We will look at the policies Riverview has adopted, as well as present practice in the Hospital.

B. NURSING QUALITY ASSURANCE COMMITTEE REPORT

The Nursing Department at Riverview undertook its own review of restraint practices several years ago. After identifying that the issue of restraints was a leading concern of the Hospital's nursing staff, the Nursing Quality Assurance Committee initiated a two year project to study these concerns. In 1991, the Committee produced the report: "Use of Restraints at Riverview Hospital." The report provided results of a survey of Riverview nurses concerning restraint, including preferred alternatives to restraint, restraint measures used and whether patients should be involved in decisions about restraint.

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[13] ***Mental Health Act***; RSO 1990, c. M7, s.1.

The study made several recommendations:

- that Riverview Hospital philosophy reflect both the values of protecting self and others, and of minimal intervention with patients' freedom;
- that the draft Charter of Patient Rights contain a right of patients "to be free from chemical and physical restraints, except when necessary to protect the patient from injury to himself or others....";
- that Hospital policy define restraint broadly, to take in all forms of "mechanical, chemical and environmental" restraints;
- that information on restraint use be included in brochures for patient, family and public awareness; and
- that Practice Guidelines be developed with respect to use of restraints.

The development of Practice Guidelines in this area has continued. The draft Guidelines we reviewed were directed at standardizing approaches to the use of restraint and ensuring restraints were used only at certain specified stages of "escalated" behaviour beyond "verbal threats." They also emphasized that patients be involved in discussions of restraint measures before they are employed.

The Nursing Department at Riverview took the lead to address the issue of improved standards for restraint. By simply raising staff awareness of problems in the use of restraint, its use has been reduced in favour of alternative approaches. These staff-generated initiatives ought to continue to be encouraged by administration.

Several of the suggestions made by the Nursing study have been incorporated into Riverview policy. In the discussion that follows, we adopt classifications of restraint used in the Committee's report, as well as in Riverview policy. The categories are:

- Mechanical,
- Physical,
- Chemical, and
- Environmental, including:
  - Seclusion
  - Locked Wards
  - Grounds Privileges
  - Clothing Restrictions (Pajamas)

C. RIVERVIEW POLICY ON "USE OF RESTRAINTS"

In early 1993, Riverview adopted Policy CRI-020 on the "Use of Restraints." The policy represented an improvement on its predecessors, in that it brought all forms of restraint (except clothing restrictions) under one general standard, which incorporates concepts of "least restrictive measure" and consultation with the patient or family. We quote from the policy:

"POLICY

Only those restrictions or restraints deemed acceptable for protecting patients from harming themselves or others may be used. A written physician's order documenting the type and the duration of the restriction or restraint is required.
The monitoring and evaluation of all types of restrictions or restraints used must be documented.
NOTE: It is not acceptable to use any type of neck hold/ restraint.

PROCEDURE

Assessment Process

1. *The assessment process will include the following and be documented on the patient care plan.*
    - *Patient was assessed to be at risk to self and/or others.*
    - *Patient, family, or significant others were involved, where appropriate, in determining therapeutic measures.*
    - *Patient was given explanation and offered choices.*
    - *Emphasis was placed on use of the least restrictive measure or approach.*
    - *Evidence of multidisciplinary involvement.*

2. *Only those restrictions/restraints deemed acceptable for protecting patients from harming self and/or others may be used."*

We note that while the policy refers to monitoring and evaluation, it does not require a mandatory reassessment by a physician at specified periods. We believe such a provision should be included for every form of restraint.

RECOMMENDATION

5-13 That the Riverview Hospital restraint policy require that a physician must reassess the continued need for restraint at specified minimum periods of time.

D. TYPES OF RESTRAINTS

We discuss four types of restraints in this section. Mechanical restraints are used infrequently and did not pose a major concern to those with whom we spoke with. Environmental restraints were of greater concern to patients and their advocates.

■ Mechanical Restraint

Policy CRI-020 defines "Mechanical Restraints" as follows:

> *"1. Mechanical Restraints are safety devices that may be used to assist and/or restrain a patient, to control behaviour dangerous to self or others.*
>
> *2. Safety devices used for the purpose of positioning physically disabled/fragile patients (e.g. bedrails, lap belts) or for treatment (e.g., IV boards, wrist restraints) are subject to the same considerations as those used to restrict behaviour. A written physician's order specifying type or restriction/ restraint and duration is required."*

The policy goes on to list a number of approved restraining devices, including several related to "geriatric chairs." The list does not include straight jackets, but does refer to "jacket with tubes in sleeves."

We learned that mechanical restraints are generally used in only two of Riverview's five Program areas: the Organic Brain Syndrome/Medical-Surgical and the Geriatric Psychiatry Programs. The main purpose is to prevent injury to patients with little motor control who may fall from beds or chairs. We were further advised that restraints had been used on only one patient in the Acute Assessment and Continuing Treatment Programs in the past several years, and that situation had been the subject of considerable discussion and review both during and after its occurrence.

We did not review the use of mechanical restraints in the two Program areas specified in detail. We encourage Riverview to continue its efforts in the area of Nursing Quality Assurance to ensure that unnecessary resort to these devices does not occur. Our impression from interviews with present and former patients is that mechanical restraints do not pose an issue at Riverview for them. Given that many of those in the programs where mechanical restraints are used are unable to fully express themselves, however, internal and automatic monitoring becomes that much more essential. Concerns were, on the other hand, expressed about restraint devices used in emergency and psychiatric wards of acute care hospitals.

■ Physical Restraint

Physical restraint is the application of force by a person to restrict the movements of a patient. Policy CRI-020 states:

> *"1. Physical Restraint/Control may be used in those situations where all verbal and paraverbal techniques have been exhausted, and the patient continues to present a danger to self or others.*
>
> *2. Use only as much force as is required to contain the situation, allowing the patient the opportunity to regain control at their own pace."*

"The one time I complained about medications, I was told that if I didn't take it orally, then they would inject me with it. They kept me pretty doped up and I wanted them to cut it down. I was groggy and couldn't think..."

A patient

Riverview also adopted Policy STA-140 in early 1993, which states that all "direct care" staff will undergo initial training in the "Non-Violent Crisis Intervention Training Program," with regular re-training. The Program, developed in the United States, provides training appropriate for limiting physical intervention to a last resort, and for maximizing patient and staff safety. Prior to this, staff did not receive standard training in interventions. This had been a serious concern.

■ Chemical Restraint

Chemical restraint, or "Medication Intervention" as it is termed in CRI-020, refers to the use of pharmaceuticals for behaviour control purposes. The Policy states:

> *"Medications may be administered to assist any patient to control behaviour which is dangerous to self or others. A written physician's order specifying type of medication, dosage and duration is required."*

The recognition that medications are used for this purpose is itself a breakthrough, as in the past medications have only been identified with active treatment. Sedatives and heavy anti-psychotics continue to be used to settle disturbed behaviour as well as to treat symptoms of illness.

We heard from several patients who perceived "getting a needle", as a disciplinary threat held over their heads. This perceived "threatening" behaviour on the part of some staff represented a particular indignity for these patients. We think this form of administering medication to an unwilling patient requires specific mention in the policy on restraints, in order to enhance the opportunity to monitor and review its appropriateness.

RECOMMENDATION

5-14 That Riverview Hospital policy on chemical restraint, or "medication interventions", make reference to the need to administer medications in the least invasive manner possible, and only in association with non-threatening communication intended to explain to the patient the need for, and nature of, the medication being administered. In addition, the policy should require that the reason for the medical intervention is recorded by the physician.

■ **Environmental Restraints**

Policy CRI-020 states:

"1. When environmental restraints are used, attention must be given to both the needs of the individual patient and groups of patients.

2. Forms of environmental restrictions which may be considered for use are:
* *ward and grounds privilege programs*
* *time-out in seclusion*
* *seclusion*
* *locked wards*

3. A written physician's order specifying type of restriction and duration is required."

■ Seclusion as an Environmental Restraint

Seclusion means putting a patient alone in a locked room. In January 1994 Riverview Hospital adopted a new Policy CRI-025 on Seclusion. It starts with this definition:

> *"Seclusion: The placement of a patient in a designated seclusion room for level III behaviour."*

"The events of being taken to seclusion, arriving in seclusion, having clothing and belongings removed, dressing in hospital pajamas, and having the door locked evoked such comments as 'frightening', 'depressing', 'degrading', 'humiliating', 'loneliness', 'anger', and 'guilt,' by the majority of subjects. Two responses were, "I was scared to death that no one would come back" and "I felt alone and started to cry."

The View from Within: How Patients Perceive the Seclusion Process.[14]

This refers to a four level description of disturbed behaviour developed for the Non-Violent Crisis Intervention Program, which now serves as the basis for Hospital staff training on interventions. Levels I and II refer to anxiety and defensive behaviour, with the latter possibly involving "verbal acting-out behaviour." Level III is termed "Acting Out" and is defined as:

> *."..total loss of control which can involve physical aggression. The individual is no longer able to control himself and verbal aggression turns into physical assault. The person may assault staff, other people or even attempt to harm himself (herself)."*

The policy is accompanied by detailed practice guidelines which set out the respective duties of nursing, health care worker, and medical staff in seclusion incidents. Among other things, the guidelines state that nurses can place a patient in seclusion if the patient's behaviour is assessed at Level III; that the attending physician should then be immediately notified; that the physician must examine and assess the patient within one hour of seclusion starting, and if it is to continue, write an order; that the duration of a seclusion order is eight hours; that the physician must reassess the situation not later than one hour after that eight hour period; and if seclusion continues beyond 24 hours, that the patient be transferred to a locked ward. After 48 hours, the Program Director must be notified to review the circumstances and approve any longer period of seclusion.

[14] Norris, M.K. and Kennedy, C.W.; "The View from Within: How Patients Perceive the Seclusion Process"; Journal of Psychosocial Nursing, Vol. 30, #3, (1992)

Compared to its predecessor, this new Policy is clearer in specifying that physical (not verbal) acting out by the patient is necessary before seclusion can be ordered. It also gives more detailed instruction on the monitoring of the patient's physical and emotional condition while in seclusion, and on the need to explain to a patient the relationship of seclusion to the overall treatment plan. Seclusion in terms of this Policy is distinct from "Time Out in Seclusion", described below.

Wards in the Acute Assessment and Treatment Program (AATP) in Centre Lawn, and the Continuing Treatment Program (CTP) in East Lawn, have one or two "siderooms" or "quiet rooms" that are used for seclusion purposes. The siderooms are bare, except for a mattress on the floor. They do not have toilet facilities. Patients placed in seclusion usually have all clothing removed except underwear. Staff can observe patients in a sideroom through a window in the door. The patient will be observed constantly, or not less than every 15 minutes, depending on the physician's order. Nursing procedures specify that a patient is to be taken out of seclusion every two hours to use bathroom facilities.

We obtained the recent statistics on the use of seclusion at Riverview which were made available on our request. We were advised that statistics are collected by Nursing in each Program area and forwarded to the Vice-President, Patient Care Services at the end of each fiscal period. Figures for the 1993-1994 year ending March 31, 1994 are as follows:

TABLE 2
FREQUENCY AND DURATION OF SECLUSION

Program	No. Patients Secluded	Total Hours	Average Length (hours)
AATP			
	233	1,871	8.0
CTP			
	408	3,590	8.8
OBS/MED			
	55	328	6.0

We sought statistics both to get an idea of the prevalence of seclusion orders at Riverview, and to see the quality assurance checks that were in place. In our view, keeping regular (i.e., monthly) records on the use of seclusion and other restraint measures on a ward-by-ward basis is important to quality assurance. A rise in the use of seclusion in a particular part of the Hospital would signal the need for review. A decline in the number of seclusions might help identify where useful alternatives were being employed. We were not satisfied that records of this type are currently being kept.

The Nursing Quality Assurance Committee at Riverview has introduced a program whereby nursing stations on each ward at Riverview are charged with developing their own auditing system for critical indicators. This directs nursing staff to consider what are the principle patient care "issues" on the ward, and determine ways of measuring them. For wards where impulsive or assaultive patient behaviour is an issue, statistics on seclusion use would likely be an important measure. While we understand the value in getting line staff to take on the responsibility for designing meaningful quality assurance measures, we believe the Hospital has a responsibility to ensure certain consistent records are kept. Seclusion use by wards is one such record.

RECOMMENDATIONS

5-15 That Riverview Hospital ensures that "use of restraint" records be kept by all wards on a monthly basis, using a standard format that would yield consistent and comparable data on several factors, including number of restraint incidents, nature of restraint employed, who ordered (doctor and/or nurse) and duration of restraint on a hospital-wide basis.

"Time out is not a treatment model -- it's just a nice word for the use of penalty....Time out is the same as seclusion and there's no way that nice words can take (it) away. In 'time out' you go in the seclusion room and you stay in there until they decide that you're rational and calm enough to come out. "

A patient

5-16 That in the design of any new psychiatric hospital on the Riverview site, or renovations to existing patient care buildings at Riverview Hospital, rooms used for seclusion meet the highest standards of comfort consistent with safety and privacy for patients and staff, including toilet facilities.

Is Seclusion Counter-Therapeutic?

We ask this question because of the serious concerns expressed about seclusion in the course of this investigation and noted in published studies of patients' perceptions.

"Seclusion rooms are an outdated form of treatment, and are cruel and inhuman. Their use should be extremely limited and should be governed by strict guidelines in order to prevent further harm to the individual."

from "Voices of Experience"[15]

Riverview's policy states that the only type of seclusion order that has therapeutic use is that known as Time Out in Seclusion ("TOIS"). TOIS can be part of a patient's treatment plan if authorized in advance by the attending physician and a psychologist, as a response to specified conduct on the part of the patient. Clearly, TOIS is viewed as a tool of behaviour modification for some patients. We were advised, however, that there are very few TOIS orders written for Riverview patients -- in fact, only four over a two year period, all for the same patient.

The great majority of seclusion orders at Riverview are therefore done for stated reasons of controlling behaviour that may threaten harm to self or others. Although in many cases the termination of seclusion is associated with the patient's returning to calm, we do not consider it fair to refer to it as therapy.

If seclusion is not generally a therapeutic instrument, is it actually counter-therapeutic? Many who spoke to us believe that placing an individual with mental illness in isolation, cut off from human contact, and with limited sensory stimulation, can have negative consequences. We share that belief. The document "Voices of Experience: Thoughts about B.C.'s Mental Health Law from Those Who Have Directly Experienced It" provides considerable insight into patients' views on seclusion. Notwithstanding these negative implications of isolation, individuals may still choose to be alone in order to limit stimulation temporarily and to maximize their privacy. The latter does not constitute "seclusion" as we discuss it here.

At the same time, we also recognize that means must be available to deal with behaviour that poses real risks to staff and patients, and that seclusion has long been one of those means. We were told that seclusion is used much less frequently at Riverview than it was several years ago. Several wards rarely use their quiet rooms. Indeed, seclusion is likely much more prevalent in psychiatric units in the Province's acute care hospitals than at Riverview. It is encouraging to know that seclusion, and other forms of restraint, can be reduced through staff awareness of, and training in, alternative methods of coping with disruptive behaviour.

[15] Trott, B. and O'Laughlin, P. "Voices of Experience: Thoughts about B.C.'s Mental Health Law from those who have directly experienced it". (1991)

RECOMMENDATION

5-17 That Riverview Hospital seclusion policy specify that where a patient is placed in seclusion by nursing personnel pending an assessment and order of seclusion by a physician, that the nurse in charge co-sign the seclusion order.

■ **Locked Wards**

Certain wards at Riverview are locked. Locked doors prevent ward patients from exiting at will. Several wards in the Geriatric Program are locked, for the safety of patients who might wander away in a disoriented state. In the Adult Division, fewer wards are locked; those that are, house involuntary patients who are considered serious risks for escape ("elope"), or who may harm themselves or others. Nevertheless, patients on locked wards have varying degrees of grounds privileges, so do not necessarily face total restriction of movement.

"There's nothing to do on the wards and there are locked doors everywhere!"

A patient

We were concerned that no criteria for deciding when a ward will be locked are established, nor are there set criteria for deciding when a patient is transferred to a locked ward. Further, we are aware that informal patients have, on occasion, been placed on locked wards for administrative convenience. This raises the same inconsistency between legal status and use of environmental restraint as pertains to seclusion. We believe that informal patients should never be placed on locked wards.

RECOMMENDATION

5-18 That Riverview Hospital develop standards for locked wards and criteria for deciding when it is appropriate to transfer a patient to a locked ward. Informal patients should not be transferred to locked wards unless their status has first been reassessed and changed to involuntary.

■ **Grounds Privileges**

"Grounds privileges" is the phrase used at Riverview to refer to the restrictions placed on patients' movement on Hospital premises. Riverview Policy sets out four categories of privileges:

"a. Ward Privileges
The patient is not permitted off the ward except under staff escort (one-to-one) for diagnostic or therapeutic purposes.

b. Supervised Privileges
The patient is permitted off the ward for meals and therapeutic/diagnostic purposes under staff supervision. One staff may supervise a group of patients.

c. Limited Grounds privileges
The patient is permitted off the ward unsupervised within Hospital grounds over specified periods of time and under specified conditions to attend prescribed activities or to walk about the Hospital grounds.

d. Full Privileges
The patient is permitted on Hospital grounds, unsupervised, within specified hours."

The Policy goes on to state the hours within which patients may exercise limited or full grounds privileges as going from the end of breakfast and morning medications to 5:00 p.m. (Winter), 8:00 p.m. (Spring and Fall), and 9:00 p.m. (Summer).

The use of the word "privileges" is, as our definition above suggests, problematic. It makes it seem that freedom of movement is a privilege, rather than a right that is denied to some patients some of the time on the basis of their mental condition. We feel it reinforces a view that grounds "privileges" are given to patients as a form of reward and punishment that helps modify their behaviour. It was clear from our interviews with patients that decisions to withdraw privileges are experienced by them as punishment.

To what degree is an "incentive" concept of grounds privileges consistent with other aspects of treatment at Riverview? We ask that question because it seems that seeking to control or modify behaviour in this way does not necessarily accord with the view that major mental illness is not primarily a behavioral issue. Clearly, there are reasons why individual patients might be subject to varying degrees of security -- mainly because their condition poses a risk to self or others. That is different from a behavior modification rationale, which we believe exists in the minds of patients and staff alike, and deserves scrutiny and review.

Riverview Policy appears to recognize health as the basis for grounds privileges in stating: "Privileges are specified in stages consistent with the patient's level of functioning." We understand the Policy is currently being studied with a view to moving more clearly in this direction. We believe it important that patients be able to complain and seek review about decisions on grounds privileges, to ensure they are not used as a casual form of punishment unrelated to health issues. It may also be important as part of this in-Hospital review to characterize grounds access as a right rather than a privilege, to be restricted only for clinical reasons.

The Hospital's Charter of Patient Rights provides a starting place, with its conditional guarantee of outdoors access:

> *"The right of generous access to the out-of-doors daily. Normally, this will be no less than 90 minutes unless this puts the patient or others at risk or if staffing is not sufficient."* (I, 19)

■ Pajamas

Riverview policy with respect to restricting clothing choices for patients is as follows:

> *"POLICY*
>
> *The dress code for patients shall reflect principles of normalization, and patients shall be dressed in appropriate clothing at all times. If patients do not have suitable clothing of their own, the Hospital may provide assistance in obtaining clothing for the patient.*
>
> *PROCEDURE*
>
> *1. Pajamas shall be considered "appropriate dress" only in the following situations:*
> - *at bedtime*
> - *when the patient is acutely physically ill;*
> - *for control purposes when the following conditions are fully met:*
>
> *(a) until examined by a physician at the time of admission or upon return from Extended Leave or Unauthorized Absence (only if the pre-examination period is two hours or less);*
>
> *(b) as prescribed by a physician and recorded as a medical order. Pajama usage for control purposes shall be so*

ordered only when specific security indications are documented in the context of an individual treatment team.

2. *Patients dressed in pajamas will be confined to wards, unless escorted off the ward for medical appointments."*

"Going to Riverview created an incredible feeling of isolation... I felt all alone and cut off from the rest of the world. I had all my clothes taken away and was placed in pajamas for a week. That's humiliating."

A patient

It might be argued that restricting patients to pajamas is not a form of restraint, in that it does not effect a physical barrier to free movement. It does, however, constitute a form of psychological restraint, which is no less real than a physical restraint. It is also experienced as "punishment" by many patients.

The policy reflects that restricting a patient to pajamas is done purely for control, rather than therapeutic, reasons. Generally, pajamas are ordered where a concern exists that an involuntary patient may try to leave the Hospital without authorization. The forced wearing of pajamas is intended to deter attempts to leave, and presumably makes it easier to recognize a patient who goes on unauthorized leave.

The implications for the patient's dignity and self-respect suggest that pajama restrictions should be used sparingly. Indeed, one wonders, in the interests of fairness, how many circumstances can justify the measure. While most wards in the AATP and CTP areas are unlocked, and so provide minimal levels of security with respect to patients' coming and going through the course of the day, it nevertheless seems that alternatives to pajamas should exist for keeping at-risk patients on the wards in most situations. Clothes can contribute to a sense of well-being, and, therefore in this setting should be encouraged.

Riverview was not able to provide us with statistics on the number or duration of pajama restrictions, as these are not collected (apart from being recorded in individual patient charts). We believe this form of undignified restriction on individual freedom requires monitoring, through records gathered on a ward-by-ward basis or, alternatively, replace the present practice other than in exceptional circumstances such as when the patient is physically sick.

RECOMMENDATION

5-19 That in addition to monitoring the use of restraint measures, Riverview Hospital keep records on the frequency, duration and reasons for restricting patients to pajamas.

E. A MECHANISM TO REVIEW THE USE OF RESTRAINT

We support the initiatives noted above by Riverview Hospital nursing staff and physicians to reduce reliance on restraint measures to control difficult behaviour. To make decision-making around the use of these measures less arbitrary requires the development of a review process. Patients who are subject to restraint measures, which are often experienced as punishment and an insult to personal dignity, must know they have avenues for complaint and review. They must have confidence that those avenues are fair.

."..what needs to be done is to have a patient advocate on each ward -- someone the patients know and have access to. Then the advocate can take the complaints to the proper people."
A patient

In Chapter Eight we discuss the need for an overall system for coordinating the handling of complaints at Riverview Hospital. One of the recommendations we make is that the position of Patient Relations Coordinator (PRC) be created at Riverview Hospital. That position would have a responsibility, among others to ensure that complaints are referred to the appropriate internal processes for review and resolution.

Complaints by patients or their families about restraint measures and privileges deserve a particularly sensitive response. A patient may complain about the facts surrounding a specific incident of restraint -- for instance, whether the facts justified a decision to place the patient in seclusion; or, a complaint might be made about the repeated use of restraint or withdrawal of privileges by the patient's treatment team. Depending on the nature of the complaint, a different kind of response may be appropriate.

We have already referred to one internal process at Riverview which may be appropriate for certain complaints related to restraints. The "Patient Abuse by Staff" policy defines abuse as:

> *"any act or omission which may cause or causes physical or emotional harm or injury to a patient or where it would be reasonable to expect that harm or injury might result. Examples of abuse include:*
>
> *a)...unauthorized use of physical restraints and/or seclusion"*

We agree with this broad definition of "abuse." Some forms of restraint may be abusive -- certainly if restraint is applied with malicious intent, as a form of retribution, or without reasonable medical evidence that warrants its use. "Unauthorized" physical restraint or seclusion is a more specific form of abuse. This addresses instances where staff use restraint without the required medical authorization or justification. An incident investigation, as discussed elsewhere, follows a standard process, and may have disciplinary consequences.

A treatment review by second opinion, or by Medical Services review, would be appropriate where the use of restraint was clearly incorporated in a treatment plan, rather than being a one-time response to a particular set of circumstances. It would also be appropriate where a patient was repeatedly being restrained, indicating a serious ongoing problem.

We have emphasized in our discussion of restraint and privilege issues that these have implications that go beyond a strictly therapeutic, or medical model. Certainly for many patients, they are experienced as forms of behaviour control, even punishment. We believe that must be recognized when designing an appropriate process for responding to complaints about the potential misuse of these measures. If a form of treatment review or second opinion was to be made available, it might be preferable for this to be provided by a multi-disciplinary team drawn from programs other than the one in which a particular case arose. In fact, a roster for a rotating "review team" might be drawn up for this purpose.

For the same reason, we believe there is the need for non-medical administrative involvement or supervision of these complaints. This is a role that could be assumed by the proposed Patient Relations Coordinator. It may also be satisfied by ensuring that the complaints policy adopted by Riverview Hospital provides for a second level appeal to the President or a Committee of the Board of BCMHS (see Chapter Eight).

RECOMMENDATIONS

5-20 That Riverview Hospital develop a process to receive and respond to complaints by patients who feel that they have been unfairly or inappropriately restrained, including where they had grounds or clothing privileges restricted. The process should respect the principles of administrative fairness and therefore involve a review of the decision to restrain or restrict "privileges", and should permit the patient to be heard. Information about the review process should be included in orientation materials for both patients and families, and be posted on all wards.

5-21 That the Ministry of Health engage in a consultative process to examine ways in which decisions to use physical and mechanical restraints, and seclusion, in psychiatric hospitals could be made subject to review by the Review Panel or other administrative tribunal.

CHAPTER SIX
TREATMENT CONCERNS AND REVIEW MECHANISMS

The purpose of Riverview Hospital is to provide treatment of persons with serious mental disorders. Treatment is a region of great silence when it comes to review mechanisms. That is largely because "treatment", which is capable of being defined so broadly it takes in most aspects of a patient's life in a psychiatric hospital, has been largely the domain of the clinical professional. Investigations or reviews of treatment had been almost by definition, restricted to that domain as well.

"The theory of a therapeutic alliance between patient and treatment staff may be used at the top levels, but it's difficult to have that philosophy float down to the reality of life on the wards. Everyone at Riverview will say that they value individual patient rights and that the hospital's goal is to move the patient into the community. While these words are easily spoken, there is a real embeddedness of the custodial model at a hospital like Riverview."
A member of a community group

The activities of the Ombudsman in a mental health setting serve as an example. The ***Ombudsman Act*** gives authority to the Ombudsman to investigate "matters of administration." Administration does not include the therapeutic decision. The Ombudsman reviews whether appropriate channels for investigations of clinical matters exist, and whether they operate fairly both for complainants and treatment personnel. She does not conduct investigations about the merits of the treatment decision.

Similarly, the Review Panels have a jurisdiction that extends only to whether a patient does or does not fall within the statutory criteria for involuntary detention. The Panels do not review the nature or quality of treatment being provided to a patient.

Because treatment is not presently reviewed by any external body, there is a heavy onus on Riverview Hospital to ensure quality standards, openness to new ideas, and extraneous considerations do not interfere with treatment decisions. The latter refers to a real or perceived danger that treatment might interfere with patient advocacy. In an environment where treatment often involves restrictions on movement and medications that affect mood and thought patterns, this danger is apparent and real.

Part II of the Riverview Hospital's Charter of Patient Rights speaks to the Hospital's obligation to protect the rights of patients in the therapeutic setting. It addresses aspects of what we have termed the gap in review processes, as is evident in the preamble to Part II of the Charter:

"Therapeutic advocacy emphasizes the right of patients to be involved in treatment decisions. Patient involvement in treatment decisions involves the right to be fully informed of treatment options and for voluntary patients to give consent freely. This enhances the patient's ability to strive toward improved health and to make a commitment to a post-discharge treatment plan.

This approach includes consideration of therapeutic alternatives, second medical opinions, choice of caregiver, clinical safeguards, information about treatment, access to caregiving persons, discharge plans and adequate supervision."

In this Chapter, we look at the therapeutic relationship, the nature of psychiatric treatment, concerns regarding treatment and the adequacy of existing review processes. We make recommendations directed at further opening this crucial and central area of Hospital activity.

1. BACKGROUND

In order to appreciate the treatment concerns and implications of treatment review mechanisms that are or are not available at Riverview, we think it important to review general therapeutic relationships and the nature of psychiatric treatment.

A. THE THERAPEUTIC RELATIONSHIP

"It's important that patients be welcomed to participate in their treatment plans. Generally, patients have too few choices to make when they are in the hospital and too many choices when they are discharged into the community. The transition has to be made smoother."
A member of a community group

Most people have a good sense of what the therapeutic relationship between a doctor and a patient involves. The patient seeks the expert skills of the doctor in diagnosing and treating physiological conditions. The doctor, in fulfilling ethical and professional obligations, informs the patient of possible diagnoses, treatments and consequences, and obtains the patient's consent to a course of treatment. Patients may rely on the expertise of medical practitioners to greater or lesser degrees, but retain control over that general course of treatment. The doctor is obliged by the Hippocratic oath to let no other consideration come before the health of the patient. The doctor also owes a duty of confidentiality to the patient. Information about the patient's condition cannot be disclosed without the patient's consent. Ideally, the relationship is collaborative, based on the doctor's recognized expertise and the necessity for the patient's agreement.

In a mental health facility like Riverview, the ideal of the therapeutic relationship is much the same. The desired goal in psychiatric care is that the patient enters into a therapeutic alliance with her or his psychiatrist and treatment team. The alliance should involve active discussion and

awareness of proposed treatment with the patient, the patient's input on treatment options, the patient being listened to and respected, and ultimate agreement on treatment goals and strategies.

The reality is, however, different. First, provincial law authorizes the detention of persons with mental illness for purposes of treatment against their will. Most Riverview Hospital patients are there involuntarily. They have not sought out the therapeutic services of the Hospital. Second, involuntary patients do not have legal authority over their treatment. The legal basis for collaboration in the therapeutic relationship, taken for granted in other medical settings, does not usually exist.

Third, there is the matter of the nature of illness being treated and the particular treatments being provided. Major mental illnesses, whether bipolar affective disorders, schizophrenia, or others, frequently involve significant impairments of judgment and cognition. Many mental patients require considerable support and may be unable of giving a fully informed consent to psychiatric treatment, especially during periods of acute illness.

Standard psychiatric treatment for major mental illnesses involves the prescribing of anti-psychotic medications, or "neuroleptics." These medications are intended to combat the symptoms of psychosis, most particularly, delusional thought patterns. However, the drugs also have side-effects that impair communication skills and mental acuity. Common side-effects are slurred speech, drowsiness and slowed responses.

For all these reasons, the therapeutic relationship familiar to medicine is challenged in the setting of a psychiatric hospital like Riverview. It presents a challenge for both clinical personnel and patients.

B. THE NATURE OF PSYCHIATRIC TREATMENT

A few comments about the nature of contemporary psychiatric therapy, its possible shortcomings, and a promising recent development that is having an impact at Riverview Hospital.

"When I first arrived, it was scary because I did not know what to expect. I noticed that a lot of patients seemed to get injected with medications."

A former Riverview Hospital patient

The basic treatments used to treat major mental illnesses by modern psychiatry are pharmacological. Since the 1950s, the development of drugs that alleviate psychotic symptoms has had a profound effect on psychiatry, psychiatric hospitals, and community mental health care. Recent new medications, like Clozapine and Risperidone, have been hailed as further breakthroughs that offer hope to those people traditionally served in a hospital for community living that did not exist before.

At the same time, the reliance of psychiatry on chemical therapy remains a subject of considerable controversy. Many critics of psychiatry and institutional care believe that the main purpose of anti-psychotic medications is to sedate patients and make them easier to control while social or environmental causes of mental illness go ignored and untreated.

It is not appropriate for us to enter into the ongoing debate over the causes of mental illness, or the efficacy or potential harm of drug therapy. We encountered an almost universal view amongst those professionals and families we interviewed: that treatment of major mental illness starts with medications. One person put it, "without knocking down the symptoms of schizophrenia or bipolar disorders, nothing else is possible." This view, however, is not universally shared by patients.

We noted frequent concern among those interviewed that too often, medication is all that is offered. Many patients we spoke to felt that their treatment at Riverview amounted to no more than taking pills, or receiving an occasional injection. Family members often shared this view, and worried about the lack of alternative or complementary treatments or programs for their loved ones.

"My doctor, in the community, indicated that I should receive sexual abuse counselling, but I've had none at Riverview. In fact I've had no talking therapy since I arrived. My social worker wanted to help me talk about the abuse but that didn't happen."

A patient

■ Counselling for Sexual Abuse

One issue in particular was drawn to our attention. Society as a whole is becoming increasingly aware of the prevalence and devastating consequences of childhood sexual abuse. Many believe that often abuse lies behind the kind of breakdowns associated with mental illness. A 1989 study by a Riverview Hospital social worker revealed a high proportion of female psychiatric patients with personality disorders who had experienced childhood sexual abuse.[16] One psychiatrist expressed his concern that while this may also be true of clinical depression, medications and Electro-convulsive Therapy (ECT) remain psychiatry's principle treatment responses.

Some Riverview patients say that little interest was shown in exploring their pasts, and that histories of childhood abuse were ignored. This was true even for patients placed there as children because of sexual abuse experiences. They felt the only healing that occurred was due to counselling received in the community. The sister of a long-time Riverview Hospital patient told us how frustrated she was that her sister had never been counselled with respect to childhood abuse, and only received medication. Another woman, placed there as a child as punishment for

[16] Mussell,E.; "Sexually Abused as a Child - Psychiatric Patient as an Adult"; 1989; Riverview Social Work Committee.

familial abuse she suffered, had to endure sexual abuse after her admission. The root of her problems was virtually ignored.

Riverview Hospital does not presently offer specific counselling with respect to past sexual abuse. We were given several reasons for this. Hospital psychologists told us that it takes time to build a trusting therapeutic relationship between counsellor and patient, and many patients are there for less than three months. Since continuity with a therapist can rarely be maintained following discharge, it is better in their opinion, for patients to receive counselling in the community. Anecdotally, we were told that some psychiatrists believe discussions of historic abuse cause more distress than they relieve.

We find this a disturbing gap in a facility intended to treat mental disorders. It means that counselling is also not readily available should a patient be the victim of sexual assault by another patient or staff member while hospitalized.[17] It also fails to recognize the real potential and vulnerability of these victims, women, often to being re-victimized while hospitalized.

Indeed, counselling or psychotherapy is made available to few patients at Riverview. Such therapy is viewed generally as the domain of psychologists, not psychiatrists. The principle activity for Riverview Hospital psychologists, however, is the testing and assessing of personality disorders. Of course, informal counselling can be, and often is provided by nurses and other Riverview staff. Providing additional counselling, or "talking therapy", is a question of resources. We believe this need must be addressed, both by Riverview Hospital and the Ministry of Health in its funding capacity.

RECOMMENDATION

6-1 That the Ministry of Health provide additional funding to Riverview Hospital for the purpose of expanding counselling and psychotherapy services for Hospital patients, particularly in the area of sexual abuse counselling for patients/survivors, and that the Hospital incorporate these services into its clinical programs.

■ The Psychosocial Rehabilitation Movement

We wish to mention the Psychosocial Rehabilitation "(PSR)" Movement, which is increasingly being adopted in Riverview's programs. The PSR philosophy is that treatment of persons with mental illness requires much more than chemical therapy. It requires a multi-disciplinary approach that

[17] The new policy on "Patient Abuse by Staff" (CRI-015), adopted by Riverview says that the President will consider the need for counselling for a patient following investigation of an allegation of abuse.

seeks to reacquaint patients with social and vocational skills, including the skills to make personal choices.

Psychosocial Rehabilitation has been defined as:

> *"Psychosocial Rehabilitation focuses on recovery of functions and quality of life issues. Techniques are rehabilitative in nature, and stress the enhancement of life skills and self confidence. It is important to the treatment/rehabilitation process that hope is continually engendered. Emphasis is on the whole person, and includes family and significant others as part of the treatment/rehabilitation network."*[18]

Three strategies to achieve psychosocial rehabilitation are identified:

- pharmacological interventions;
- psychological methods emphasizing behavioural strengths and social interaction skills; and,
- social-environmental methods that assist persons with adaptive skills for everyday living.

Supporting principles of PSR include providing as normalized a therapeutic environment as possible, making work and vocational rehabilitation central to the treatment process, and giving patients a primary role in determining their treatment and rehabilitation program.

Psychosocial rehabilitation at Riverview is presently centered in the wards of the Community Psychiatry Division, Fernwood Lodge and Brookside. The report, "Division of Community Psychiatry: A Psychosocial Review", outlines the progressive nature of this approach. Among other things, the Program has formed links with the operator of semi-independent living units and a clubhouse in Vancouver. British Columbia has an active chapter of the International Psychosocial Rehabilitation (IPSR) Association, in which Riverview Hospital staff play a significant role.

Riverview Hospital struck a Task Force on Psychosocial Rehabilitation in the Fall of 1993 "to develop options for integrating the PSR approach and appropriate services in Riverview Hospital adult programs." The Task Force reported in mid-January 1994, recommending that an implementation team be created to plan the phasing-in of PSR approaches throughout the Adult Division. This commitment to move therapeutic programs in a direction that is clearly patient-centered is commendable. We note,

[18] From a definition drafted by the Riverview Hospital Task Force on Psychosocial Rehabilitation. See also Cnaan, R.A., Blankertz, L., Messinger, K. & Gardner, J.R. "Psychosocial rehabilitation: towards a definition." Psychosocial Rehabilitation Journal (1988) 11(4), 61-77.

however, the findings of a survey done by the Task Force (based on a small sample) that showed patients and family members are much less convinced than staff members that PSR practices are currently employed in Hospital programs.

2. EXISTING TREATMENT REVIEW MECHANISMS

Many of treatment personnel -- psychiatrists, physicians, nurses and psychologists -- strive to continuously improve standards of care at the Hospital. This is reflected in the number of existing mechanisms for regular review and reconsideration of treatment issues. Below, we describe six of these mechanisms. We note that these review mechanisms are generally initiated by Hospital staff, not by patients (with the exception of complaints to professional associations). For reasons already given, a facility like Riverview Hospital faces a particular challenge in ensuring that problematic treatment issues are identified and addressed, without waiting for them to be raised by the patient.

A. WARD ROUNDS

Riverview takes a multi-disciplinary team approach to patient care. Each patient in the Hospital has a treatment team composed of a psychiatrist, general practitioner, primary nurse, and social worker. In some cases, the team will also include a psychologist, rehabilitation therapist or other consultant.

Wards hold "rounds" each week. During a ward round, individual patient cases are reviewed and discussed. Team members raise any problems of which they are aware, including medications and behaviour issues. Not every patient has her or his case discussed in this weekly session. Efforts are made to rotate the cases being presented, so that no patient is neglected in ward rounds for an inordinate period.

Patients are sometimes included in ward round discussions of their cases. This is a useful and appropriate way to air concerns but is not done as a matter of course. A few patients told us that attending ward rounds, and being surrounded by a group of professionals, is an intimidating experience. This may be one place where the presence of an advocate could play a useful role in supporting a patient.

Riverview holds "grand rounds" on a regular basis. In grand rounds, guest speakers or Riverview staff professionals give a presentation on recent research developments. Sessions are open to all interested persons.

B. AUTOMATIC MEDICATION REVIEWS

"Medications were changed weekly. I had a lot of side effects, but I just had to suffer them while I waited up to a week to see my doctor."

A patient

Riverview policy requires that a patient's medications be subject to a review at least every 90 days. In addition, medication orders written by physicians are subject to review at the Hospital Pharmacy. A psychopharmacy consultation by a doctoral level pharmacist is available to physicians on a referral basis. These are important quality assurance mechanisms with respect to pharmacological treatment considering its importance to the service delivered. We were told of one situation in which the Pharmacy alerted Medical Services of unusual prescriptions by one psychiatrist. This resulted in a finding that the prescriptions represented "novel treatment" requiring consent of the patient and a second clinical opinion.

C. CONSULTS

One of the best ways to ensure that a patient's care is subject to thoughtful review is to provide an opportunity for consults and second opinions by treating professionals not directly involved with that patient. This seeks to provide a balance in the relationship; the tenuous position of the patient due to her or his disability and the power of her of his psychiatrist to control treatment.

The review of therapeutic opinions among treating professionals helps maintain the balance. The patient's right to seek a review is of equal importance.

There are several ways in which consults come about at Riverview:

- Ward rounds by multi-disciplinary teams provide a forum for periodic review of cases across the professions.
- Every patient has both a general practitioner and psychiatrist on the treatment team, which builds in a form of ongoing medical consultation.
- Referrals to North Lawn for standard medical procedures result in consultations.
- When patients move from one program area to another, or between wards, they are transferred to new physicians. This requires consults.
- A psychiatric specialist in mood disorders presently operates a consultation clinic for all new admissions and difficult cases with this diagnosis.

- Hospital policy also requires second opinions where certain invasive treatments, like Electro-convulsive Therapy, or novel treatments, are proposed for a patient.

One physician estimated there is an average of one non-attending psychiatric consultation per patient each year, and suggested that patients are seen by so many different clinical professionals while at Riverview, that continuity of care is a greater problem than lack of peer review.

We believe that fostering a climate in which clinicians regularly seek consults from their colleagues, both inside and outside Riverview, should be an important ongoing goal for the Hospital. This is, of course, a question of physician resources as well as of program design. Riverview is moving to strengthen its affiliation with the Department of Psychiatry at the University of British Columbia. This is being done as part of an ongoing strategy to improve research capability at Riverview as it becomes a smaller, more specialized psychiatric hospital. This affiliation should, at the same time, expand opportunities for individual case consultations.

RECOMMENDATION

6-2 That Riverview Hospital develop a policy which enables clinicians encouraged to seek consultations from colleagues both inside and outside the Hospital.

D. MEDICAL QUALITY ASSURANCE COMMITTEE

Riverview has a Medical Quality Assurance Committee that monitors physicians' clinical performance in several respects. These include:

- post-mortem reviews of a case in which a patient has died, on referral from a committee that reviews every death of a Riverview patient, (the committee consists of medical personnel from North Lawn, a pathologist from Royal Columbian Hospital, and the Medical Librarian);
- reviewing clinical documentation practices at Riverview; and
- checking physician participation in continuing medical education, including presentation in grand rounds.

On occasion, the Committee may review an individual case when asked to do so by the Vice-President, Medical and Academic Affairs/Clinical Director. The Committee has the mandate to develop its own priorities with respect to reviewing the quality of Hospital medical services.

RECOMMENDATION

6-3 That Riverview Hospital direct the Medical Quality Assurance Committee to review its mandate and the way it operationalizes its mandate given the need to review clinical practices absent patient complaints.

E. COMPLAINTS TO PROFESSIONAL ASSOCIATIONS

Medical professionals are subject to the authority of self-governing professional associations. The College of Physicians and Surgeons, for instance, is empowered under the ***Medical Practitioners' Act*** RSBC 1979, c.254 to regulate the conduct and qualifications of British Columbia physicians, including psychiatrists. Complaints about a physician's misconduct or failure to meet professional standards can be made to the College. The College has powers to investigate, hold hearings and impose disciplinary sanctions.

Complaints can be made by anyone, including a patient or family member. However, Hospital officials are uniquely situated to know when a potential breach of ethical or clinical standards has occurred. We do not think it easy to put firm rules in place on this matter. We are nevertheless concerned that it is too easy to deal with problems in these areas on an informal basis, and avoid the responsibility of ensuring they receive review and scrutiny by the appropriate professional body.

RECOMMENDATION

6-4 That Riverview Hospital develop protocols with professional associations governing clinical personnel at the Hospital with respect to referral of, and reporting back on, matters with the potential for professional discipline; in particular, that Hospital policy require referral of any allegation of sexual abuse of a patient by a staff member to their governing professional body, in addition to any internal recourses or referrals to police authorities; and that Hospital policy clarify the reporting relationships between clinical departments and senior administration on matters of potential professional misconduct.

F. PROGRAM EVALUATION PROJECT

A Program Evaluation Project was initiated by Riverview in 1992. The goal of the Project is to identify every treatment program in the Hospital, and then work with the programs to develop effective methods of

measuring success. "Program" in terms of the Project does not mean the five Program areas. It refers to all sub-programs providing unique treatment, for example, the Self-Induced Water Intoxication Ward in East Lawn. Riverview programs have not previously taken a systematic approach to self-evaluation. In effect, outcomes were not being measured. This Project should prove a useful tool for ongoing review of treatment issues at Riverview.

3. ENHANCING THE THERAPEUTIC ALLIANCE

We listed six existing treatment review mechanisms available to medical and nursing staff at Riverview whereby treatment plans and decisions can be reviewed. These are critical in a setting where quality assurance cannot be dependent on patients raising concerns on their own behalf.

"Staff have to be partners with patients. They have to listen to the patients and they have to loosen up on their ego-thing. "
A patient

As we mentioned earlier in this Chapter, the desired goal in psychiatric care is for the patient to enter into a therapeutic alliance with her or his psychiatrist and treatment team. We believe that having fair processes to review psychiatric treatments available to the patient and those who advocate on their behalf will enhance the opportunity for a therapeutic alliance. The existence of fair review mechanisms and an environment of trust and openness is needed to support a partnership between mental health professionals and the patient they serve.

A. ACCESS TO PATIENT CHARTS AND MEDICAL INFORMATION

The basis for meaningful involvement in treatment is information. Much of this is best conveyed verbally, through personal interaction. A patient may also want to know the information contained in her or his medical records. A recent Supreme Court of Canada decision confirms that patients have a common law right of access to their own medical records:

> *"The doctor's position is one of trust and confidence. The information conveyed is held in a fashion somewhat akin to a trust. While the doctor is the owner of the actual record, the information is to be used by the physician for the benefit of the patient. The confiding of information to the physician for medical purposes gives rise to an expectation that the patient's interest in and control of the information will continue...."*[19]

The Court went on to say that this right of access extends to the reports of consultants in the file or chart. The Supreme Court allowed withholding

[19] ***McInerey v. MacDonald*** [1992] 2 SRC 138, at 150-151 (per La Forest, J.)

of medical records only where disclosure has "a real potential for harm either to the patient or to a third party." It defined this exception narrowly.

In addition to common law rights of access, the new British Columbia ***Freedom of Information and Protection of Privacy Act***, SBC 1992, c.61, as amended by SBC 1993, c.46 extends statutory duties to give access to personal information to "health care bodies" including "a Provincial mental health facility." The statutory provisions covering health care bodies will not be brought into effect until October 1994. At that time, Riverview Hospital patients will have statutory rights to seek access, and make corrections to, personal information maintained by the Hospital, and the right to appeal refusals to disclose to the Information and Privacy Commissioner. The process of obtaining records under the legislation starts with a written request.

Riverview's current policy on patient access to clinical records is, on its face, more restrictive than the access to information legislation and the Supreme Court's statement of the law, because it permits psychiatrists to refuse access on grounds other than potential harm to the patient or a third party. We understand a revised policy will shortly be adopted which is intended to be consistent with the new law. It provides for a review and decision by the President of Riverview where the attending physician has refused access and documented reasons for refusing access to all or part of the record.

"From day one, I was never told about my medications and found out from another patient what the drug was that they were giving me."

A patient

Both the current and proposed policies set out procedures for patients to access their records. Patients must provide a written request to the Manager of Clinical Records. The revised policy states the patient "should be encouraged to provide reasons for requesting access to ensure the most suitable assistance is given....." This implies that an assessment may be made as to whether the patient's request is justifiable. Access to one's records is a right and reasons for seeking it should not be required.

We were advised by a Riverview Hospital official in the area of medical records management that only one patient has made a formal request to review her or his file in the past four years. We find this surprising. It may be that patients do not seek intensive involvement in treatment matters. However, we think it suggests that patients are unaware of their rights and recourses available to them.

There are many subtle ways in which patients can be discouraged from pursuing certain inquiries. The mere requirement that a form be completed in writing requesting access to medical records can serve as a deterrent,

especially if ward staff do not assist with or facilitate its completion. This may be an appropriate example of where the assistance of an advocate is warranted.

The success of all treatment review and complaints handling processes discussed in this Report, both current and recommended, depend on the willingness of Riverview Hospital staff and management to foster an atmosphere of openness. This is particularly important with respect to access to clinical records. This is a legal right of patients, and one whose exercise can contribute to the patient's understanding of the treatment program, and sense of security. It should be commonplace that when a patient expresses doubt or confusion about medications, or other aspects of treatment, staff respond by inviting the patient to review the chart, and by assisting in bringing this about.

RECOMMENDATION

6-5 That Riverview Hospital revise its policy on patient access to her or his own clinical records to ensure that it is consistent with common law and the ***Freedom of Information and Protection of Privacy Act,*** and in particular, to remove unnecessary barriers to access such as the requirement to provide reasons for the request or the strict enforcement that the request be made in writing.

B. ACCESSIBLE WRITTEN TREATMENT PLANS

The idea of the therapeutic alliance emphasizes the involvement of the patient in designing and carrying out her or his treatment plan. The plan represents the goals and methods for treating a particular patient. It is developed by the multi-disciplinary team, covering medications, nursing approaches related to behaviour and living skills, and other programs related to the patient's rehabilitation. We have already acknowledged the importance of a patient's access to her or his medical records. Similarly, it is important for patients to have access to their treatment plan.

"A patient on admission should be told what medications they are to be given and why and what their side-effects are. This information should be re-iterated periodically and the necessary time taken to communicate it properly."
A member of a community group

A "treatment plan" that is an accessible and understandable document that outlines the essential elements of an overall plan does not presently exist. Instead, the "plan" is contained in notes summarizing treatment decisions of clinical staff (for example, medication orders) and a cardex record of each patient's treatment kept at ward nursing stations.

If a patient asks to read her or his plan, no single document can be provided for this purpose. In this respect, Riverview Hospital is not alone among Canadian hospitals. The Canadian Council on Health Services

Accreditation is only now introducing a standard for integrated patient care plans in the acute care sector. The Riverview Management Committee authorized the development of guidelines for a form of care plan to be introduced in June 1994. This will be an important step for staff and patients, providing them with an improved opportunity for the review, understanding and ongoing evaluation of treatment care plans.

RECOMMENDATION

6-6 That Riverview adopt a single standard form for patient care plans. These features include:

"My family are quite involved in my treatment. They understand what is going on with me better now than they used to. They come in to discuss treatment planning with staff members."
A patient

- diagnosis;
- modalities of treatment (medications, special behaviour programs, skills acquisition programs, etc.);
- explanations of what each modality intends to accomplish and how;
- prognosis;
- discharge plan; and,
- a section to record patient input and her or his signature, and

This form should be included in the progress notes on the patient's chart, and be available to the patient and Hospital personnel involved in treatment or responsible for reviewing treatment. When a patient is illiterate, marginally literate, visually impaired, blind or unable to read, the plan should be read and explained to them verbally or made available on audio-cassette tapes.

"In the acute phase of mental illness, it is not useful or appropriate to go into a detailed discussion of treatment issues until after a patient has stabilized. (Then) it should involve a complete package of information on treatment and treatment options. The hospital seeks to obtain a consent for treatment right at the outset of treatment and then act on it as if it has a blank cheque thereafter. Discussions of treatment issues should be an ongoing consultative process with patients."
A member of a community group

C. CONSENT TO TREATMENT

In Chapter Four we reviewed the legal context for psychiatric treatment decisions in British Columbia. A key aspect of that context is the deemed consent to treatment provision in the ***Mental Health Act*** for involuntary patients.

Consent to treatment is much more than a legal concept. It forms the basis of any therapeutic alliance -- the free giving of an informed consent. Regardless of a patient's status as involuntary or informal, it is therefore important that consent be sought for treatment whenever possible. Consent itself is not a mere matter of saying "yes" to proposed treatment. It emerges from a full process over time of explaining and discussing treatment options, discussing the intended effects and side-effects of medications and engaging the patient in asserting ownership over her or his treatment plan. Consent is real only to the degree to which the

answer "no" is respected by those seeking it. In psychiatry, as in other areas of medicine, a range of treatment options is usually available. Patients often reject one treatment mode or medication, but not others. Respecting a patient's choice among options, including the choice of a less-recommended option, is also a fundamental part of a therapeutic alliance.

In our view, clinical staff should work on the basis of patient consent and choice to the greatest degree possible, and not rely solely or prematurely on the legal authority to treat without consent. We believe many Riverview clinicians prefer to avoid having an involuntary patient take medications without consent, unless necessary for their own or others' protection. We are, however, concerned with the number of patients who told us they did not know what medications they were taking, and that no one had discussed medications with them.

Recently adopted Riverview policies on "consent to treatment" that stress the need to assess capability to consent of involuntary patients may not fully encourage greater involvement of patients in their own treatment. If those policies are to have substance, it requires a commitment to collaborative treatment discussion. That is also true of policy that refers to consulting with substitute decision-makers (often family members). The new guardianship legislation may result in more families acquiring a substitute decision-making role with their vulnerable relatives. This presents an opportunity for clinicians to bring patients' support circles into treatment discussions.

D. REQUESTS TO CHANGE CAREGIVER

"I requested a change of doctors and it didn't come through. I was only allowed to change when I was transferred to another ward."

A patient

Part II, 4 of the Riverview Hospital's Charter of Patient Rights, states that patients have:

> *"The right to choose care-givers or care environment where possible."*

"Care-giver" is a wide term that includes nurses as well as physicians. In what follows, we refer variously to "physician" or "care-giver", but recognize that the right extends to all professions involved in providing direct patient care and treatment.

The ability to select the physician of one's choice is a hallmark of the traditional therapeutic relationship. It is constrained by such practical factors as geography, waiting lists, and admitting privileges in hospitals. Nevertheless, the health care system preserves, to a significant degree, the principle of individual choice of a medical care-giver.

At Riverview Hospital, patients have little or no choice over care-givers. This is also true of psychiatric units in general hospitals. Patients are admitted into programs designed for their treatment needs. The patient's treating physician and psychiatrist are those assigned to that ward. On occasion, where a psychiatrist has worked with a patient before, the patient may be added to her or his caselist. This is not common, and no effort is made on admission to link a patient with a particular therapist.

"One problem in the hospital is that you change doctors whenever you move from one ward to another. Therefore, there isn't any continuity in care. Patients shared an attitude: What am I doing here? I'm just taking medication three times a day!"

A patient

What happens if the patient does not feel comfortable with the assigned psychiatrist? He or she may make a request to change therapists, to the Clinical Director or the Program Director. We understand that few formal requests of this kind are made. Even less often do such requests result in a change of care-giver. If they do, this generally means that the patient is transferred to a different ward, into the care of another psychiatrist and treatment team.

In the existing procedure, the Clinical Director asks the applicable Program Director to attempt to reconcile differences between the patient and treating personnel. While this appears reasonable, the attempt to reconcile patient and doctor may have the effect of discouraging the patient from continuing with the request to change care-givers or from making the request at all.

We recognize that changing care-givers is difficult given limited hospital and budgetary resources. It may not be possible to provide a different therapist whenever it is requested by a patient. It may be that some patients would be unhappy with any care-giver and make repeated requests to change.

There will be administrative and financial consequences but having the ability to have a voice in choosing one's care-givers is central to developing a therapeutic alliance. The Hospital's Charter of Patient Rights recognizes this, and represents a positive statement of the obligation on Riverview to facilitate choice in therapists, whenever possible.

An appropriate degree of flexibility in assigning cases to psychiatric, medical and nursing staff should exist, so as to permit more changes at patient request. We mentioned earlier in the discussion regarding access to medical records and treatment plans, that access should not be based on the reasons a patient describes for wanting access. Likewise, a patient's ability to change care-givers should not be solely based on whether their reasons are judged as "good enough."

RECOMMENDATION

6-7 That Riverview Hospital develop a standard process for receiving and responding to patient requests to change care-givers, with the ability to limit the number of requests over time, on the basis of what is fair and reasonable in the circumstances.

E. REQUESTS FOR A SECOND OPINION

We referred earlier to consultations which physicians at Riverview obtain with respect to difficult cases, or when patients move between wards and programs. Here, we refer to patient-initiated consults or the right to obtain a second medical opinion. We are aware of one area in which Riverview patients have a right to obtain a second opinion. The newly adopted Patient-Sexuality Policy states that if a patient's request for access to a privacy suite is turned down on two occasions by the treatment team on the basis of the patient's mental incapacity, the patient is entitled to the opinion of a physician not on the team. The opinion of that physician will be followed. We believe a patient's ability to initiate second opinions is a key safeguard in treatment issues, and should be broadened.

The Hospital's Charter of Patient Rights states that patients have:

> *"The right to a second medical opinion and have hospital staff facilitate the obtaining of this opinion."*

In earlier drafts this was stated as a "right" only to make "a request." This was a matter of dispute between patient representatives on the Task Force that produced the initial draft of the Charter and the Riverview Hospital staff committee that revised it. Patients pointed out that the 'right to make a request' seemed insubstantial. The "right to a second opinion" came to be recognized. The protection afforded by such a right may be particularly significant with respect to invasive treatment, such as Electro-convulsive Therapy (ECT).

We note that the idea of a statutory right of hospitalized mental patients to a second opinion has gained prominence in the consultations on reforming the ***Mental Health Act***.

A number of practical questions surround this issue:

Who provides the opinion?

While it may be appropriate that a patient can request a second opinion from outside the Program area, should it come from outside Riverview altogether? Both internal and external second opinions have funding implications. Indeed, the matter of physician resources, and payment for second opinions, are problems for implementing such a right. Psychiatrist resources at Riverview are tight and may not expand in the foreseeable future. Second opinions and consults fit within clinicians' sessional hours, and so consume time available for other work. The fee-for-service schedule of the Medical Services Plan does not include fees for consultations by external psychiatrists. Nevertheless, any right to obtain a second opinion can be accommodated by opinions from physicians independent of the Hospital.

What is the effect of a second opinion?

Does the patient have the right to say that the second opinion should be followed, or does it merely constitute advice to the attending psychiatrist? The answer may depend in part on whether there are treating personnel at Riverview willing and able to offer treatment as prescribed by the opinion. The administration should carefully consider this issue.

Who "owns" a second opinion?

We are aware that referring physicians view a second opinion as theirs, a form of advice that they seek in order to assist in providing treatment. Does a patient "own" the opinion if he or she has initiated the process of obtaining it? Who is the second opinion provided to? Who gets to see it? When a patient seeks the opinion, the same rules regarding access to records should apply.

How often can second opinions be requested?

Should there be a limit of second opinion requests by individual patients, based on a number of reviews by the treatment team, or passage of time from last request?

These are all important considerations. They should not detract from the importance of giving hospitalized patients access to therapeutic opinions from clinical personnel outside the treatment team.

We note the potential conflict between treatment and advocacy. A few patients who have been active in advocacy on Hospital-wide issues believe that their efforts were hindered by restrictive treatment programs. Some felt that they had grounds privileges withdrawn because of advocacy activity. The perception that this could happen is damaging to the integrity of Riverview's patient care programs. The ability of patients to obtain a second opinion on treatment issues would help address this serious concern.

RECOMMENDATION

6-8 That the Ministry of Health and Riverview Hospital develop a program that would permit Hospital patients to obtain a second medical opinion on request. The program would have the following features:

- a standard and plain language form for initiating the request;
- recognition of the patient's right to name a qualified psychiatrist from whom an opinion will be sought, subject to availability and her or his agreement to do so;
- recognition of the patient's right to receive a copy of the opinion;
- payment by the Medical Services Plan for patient-requested second opinions, in particular for non-staff clinicians; and,
- reasonable limits on the intervals between second opinions obtained at the request of an individual patient, in light of factors such as the seriousness or invasiveness of the treatment proposed (for example, no limits on second opinions for recommended courses of treatment for Electro-convulsive Treatment).

CHAPTER SEVEN
LEAVING RIVERVIEW...

We have reviewed the legal rights of patients, the quality of life in the hospital and treatment review mechanisms that exist and that we recommend should exist. This Chapter, looks at the processes that exist to assist the patient in her or his return to the community.

First, we review the Mental Health Initiative of 1990, deinstitutionalization and its impact on Riverview's mandate as a psychiatric hospital.

Second, we address the discharge needs and concerns of the individual patient. Most patients at Riverview are in transition from Hospital to community. The key role for the Hospital in this transition is providing adequate discharge planning for each patient. Concerns are described under the headings: money, housing, transportation, information and advocacy.

Third, we consider the ability of Riverview Hospital to successfully "transfer" patients into the community; that is, the larger community of family and mental health and social services. Riverview Hospital is part of that large mental health system, and its role in that system is undergoing a significant change.

1. THE MENTAL HEALTH INITIATIVE (1990)

"The discharge planning that has been done on the downsizing program is good, but that does not extend to the 700 ordinary discharges which occur at Riverview each year. On these discharges, Riverview's mandate seems to stop at the Lougheed Highway."
A parent

Riverview Hospital is in a period of transition. The Mental Health Initiative announced in 1990 projects Riverview to become a 300 bed tertiary care facility serving only the Lower Mainland region by the year 2000. The Initiative also projects 100 tertiary care beds for each of Vancouver Island and the Thompson-Okanagan-Kootenays region, and 50 tertiary care beds for the North, for a Province-wide total of 550 beds.

The Strategic Mental Health Plan for 1992 confirmed these goals, and set out a five-year plan in which 170 beds at Riverview are to be transferred to acute psychiatric care in general hospitals around the Province.

The Initiative's plan for hospital psychiatric services, often referred to as "downsizing" or "deinstitutionalization", actually continues the 35 year-trend that has seen Riverview reduce in size from approximately 4,000 to 850 patients today.

A. THE FUTURE OF TERTIARY CARE IN BRITISH COLUMBIA

Mental health services in British Columbia are classified into three levels of care:

- Primary care provided by community mental health services;
- Secondary care involving short-term hospitalization provided by psychiatric units in general hospitals for persons experiencing an acute phase of mental illness; and,
- Tertiary care provided on an in-patient basis to those persons whose mental health cannot be stabilized or restored at the primary or secondary care levels.

The most basic meaning of tertiary care refers to a level of care that backs up primary care and secondary care. Beyond this basic understanding, however, difficulty arises. Does "tertiary care" refer primarily to specialized hospital psychiatric programs not available elsewhere? Or does it refer to long-term, institutional care, for individuals who arguably are unable to be served in the community due to lack of resources for people with a chronic serious mental illness? Or to both?

That debate surrounds the redesign of Riverview Hospital as a 300-bed facility, as well as the development of 250 tertiary care beds in other regions of the Province. At present, Riverview appears to provide both specialized (e.g., the Organic Brain Syndrome Program) and institutional or "asylum" (as it is still referred to for some purposes) care. It may not be possible to provide both at a much-reduced size.

"The Riverview grounds are the only positive thing this generation can leave to the mentally ill persons in the next century. I believe the grounds are a treasure and should not be lost to mental patients and are worth preserving . The grounds themselves are therapeutic, both for patients and staff."
A parent

The Ministry of Health has instituted planning processes for each of the four regions developing tertiary care, including Riverview Hospital. Planning Teams are composed of staff persons from hospitals and local mental health centres, and consumer and family advocates.

The planning for Riverview Hospital as a 300 bed tertiary care facility for the Lower Mainland includes consideration of the appropriate physical design. It may be that a new facility to replace the large "Lawn" buildings will be recommended. We are aware that a number of groups and individuals are concerned that the Provincial Government may sell all or part of the valuable land on which Riverview sits. They believe the grounds should be preserved for the use of present and former patients, or at the very least that the proceeds from any sale should be designated for the benefit of people requiring mental health resources.

RECOMMENDATION

7-1 That the British Columbia Buildings Corporation engage in a process of open public consultation with respect to the future use or sale of the Riverview grounds before any decisions are made on that subject.

B. BED CLOSURES AND FUNDING

We are aware that the Ministry has made transitional funding available to Riverview Hospital to support patients moving into the community as part of downsizing. In addition, Riverview Hospital returns funds associated with each year's bed closures to the Ministry which, in turn, reallocates this money to community services. In the 1992-93 fiscal year, the Hospital returned approximately $6 million to the Ministry for 105 bed closures and 67 patients discharged, and in 1993-94, will return $3.75 million for 50 closures and discharges. These arrangements are complex. We were concerned that the money returned to the Ministry of Health, despite best intentions, would not, in the end, be allocated in a way that truly benefited

those in the community. We had considered making a recommendation, therefore, that the Auditor General of B.C. conduct a value for money audit of the planning process related to bed closure transfers, and determined that this had been just undertaken in the 1992-93 fiscal year. The report is expected shortly.

Generally, individual discharge planning related to the bed closure program appears to be done with care. Transitional funding allows nurses from Riverview Hospital to follow patients for several days in their new community placements, and to make further visits for up to six months. Eased re-admission to the Hospital for up to six months following discharge was also made available to these patients and their community care service providers.

We heard concerns that bed closure discharges have the appearance of "Cadillac" planning processes compared to the more routine discharge planning not related to downsizing. The bed closure discharges indeed appear to demonstrate features of good discharge planning, including forms of "bridging" service and assertive case management, referred to later in this Chapter. However, it also needs to be recognized that, to date at least, these discharges have dealt primarily with long-term Hospital patients going to licensed boarding and nursing homes. These are situations in which comprehensive planning is most feasible. Planning for shorter-term patients presents more difficulties, and often calls for good "rapid response" planning (see below).

"The transitional issues from the hospital to the community have not received sufficient attention, just clinical issues."

A Community Group Member

Bed closures at Riverview Hospital are actually ward closures; only by closing whole wards can significant savings from downsizing be realized.[20] Riverview has project teams in each of its Program areas involved in planning closures. The teams include one representative each from the Family Resource Group, and are multi-disciplinary.

■ The Hillside Program

We want to comment briefly on one episode of closing a ward at Riverview that illustrates some of the pitfalls surrounding the process. During this investigation, we visited the Hillside program at Riverview. Hillside was a 20-bed residential ward housed in its own building on the Riverview grounds. It offered an intensive six-week program of classes in living skills, social skills, anger management, etc., using the principles of psychosocial rehabilitation both in the classes and in life on the ward. Its clients included patients from Riverview, the Forensic Psychiatric Institute, and individuals

[20] This does not mean that all patients from a single ward must be transferred from Riverview to community facilities before a ward can be closed. Rather, patients may be discharged from different wards, and wards amalgamated. This is done on a Program by Program basis.

referred from various community-based mental health services. The latter were admitted directly to Hillside as an exception to Riverview's general admissions policy. Most of the patients we met spoke highly of the program. Some called it the best thing they had encountered in years of receiving mental health services.

In the Summer of 1993, the Hillside program was closed as part of the bed closure planning for Riverview. For years there had been discussion of Hillside's moving from Riverview to a community-based site; this seemed appropriate because up to 80% of its clients were referred from the community, not Riverview.

However, at the time of its closure, there was no plan for Hillside (including its classes, trained staff, and philosophy) to have a new home. What was reported to be an excellent program, simply ended. It seems that from Riverview's point of view, Hillside was an attractive target for closure. Since it accounted for 20 beds and was not fully integrated with other Hospital programs, it was felt that little disruption would result. The Hospital also believed community mental health planners had a responsibility to sponsor the transfer of the Program if they were interested in its continuation.

For now, there is nothing to replace Hillside. This is a real loss to the patients and community. It represents a breakdown in the orderly transition of services from hospital to community. We think that if the voice of patients was brought into the planning of closures in a serious way, a program like Hillside would not have ended before its replacement took shape in the community, through the joint efforts of Riverview Hospital and the community-based services.

RECOMMENDATION

7-2 That Riverview Hospital consult in a timely and meaningful way with patients and consumers of community mental health services in the planning of bed closures.

C. "ASYLUM" PATIENTS VS. PATIENTS IN TRANSITION

Something that became increasingly apparent as our investigation proceeded was that Riverview has a divergent patient population. Generally, there are two populations: an "asylum" or institutionalized population and a "transitional" population. These differences are particularly evident when one considers the patient profiles of the Acute Assessment & Treatment Program (AATP) and the Continuing Treatment Programs (CTP). Patients on wards in CTP are, on average, significantly older and longer-stay than patients in AATP.

These differences do not appear to reflect a "snapshot" of the progress of mental illness in terms of hospitalization (i.e., the younger person with short hospital stays will become the older person with long-term hospitalization). Rather, it reflects two distinct approaches to the treatment of mental illness.

"We are seeing the end of an era in mental health. The patients in the Continuing Treatment Program are the last generation subject to long-term institutionalization."
A parent of a Riverview patient.

Listening to the parent on the left echoes the voice of many service providers. They believe the new approach calls for short-term hospitalizations, perhaps extended for rehabilitation purposes, with returns to the community at the earliest reasonable date, a cycle that might be repeated for individual patients a number of times over their lifetime.

We heard a senior staff person speculate about a future Riverview that would link the Acute Assessment and Treatment Program (AATP) wards with the rehabilitation-oriented Community Psychiatry wards, while stopping admissions into the Continuing Treatment Program (CTP). The CTP would provide asylum care to its present patient population and eventually be phased out.

Not everyone agrees this is for the best. Some professionals believe "asylum care", to the point of life-long hospitalization, is required by a small percentage of persons with mental illness chronically unable to cope with life in the community. Providing a pleasant, comfortable, and safe living environment is the first priority in asylum care. Rehabilitation comes second.

We understand the genuine concern for patient well-being that lies behind this position. However, we think it has led in the past to a tendency to "give up" on too many individuals. Energy is more likely to be spent on developing more comprehensive and sensitive community services if long term institutionalization is not considered an option. Recent discoveries in pharmacological research, such a Clozapine and Risperidone, have assisted patients who otherwise would have been hospitalized to be served in their homes. An approach to treatment that focuses on maximizing every patient's opportunity to return to life in the community seems best able to respect that possibility. Central to such an approach for those who do require hospitalization at some stage is discharge planning.

2. DISCHARGE PLANNING

The single greatest concern about Riverview Hospital expressed by family members and community mental health workers related to discharge planning. Discharge planning is a matter of administration for which the Hospital is responsible. What does discharge planning involve? It should involve planning for every major part of the patient's life as he or she moves back into the community. This may include vocational planning, finding employment, or re-integrating an individual into the life of her or his family. Traditionally, the most common features of discharge planning have been housing, financial support, psychiatric care in the community, medications, and (re-) establishing a social support network. The key Hospital staff person with respect to discharge planning is the social worker on the patient's treatment team.

"Short term discharges are usually where the problems arise. Staff for their own reasons, have felt that the person isn't ready to go out yet but the person feels they are. So they go through the Review process. If they're successful, the first thing they do is say, "I'm out of here", and they leave without any planning done on their behalf. In an ideal world, planning would start from when they first get into the hospital."

A former patient

It is important first to understand the ways in which a patient can leave Riverview Hospital. An involuntary patient cannot discharge him or herself from the Hospital. If an involuntary patient leaves the Hospital on an unauthorized absence, the Hospital may issue a warrant valid for 60 days under the ***Mental Health Act*** for the arrest and return of the patient. Hospital Policy PAT-036 states that patient's bed will be released on the sixth day of absence, but the patient will not be officially discharged until the expiration of the warrant on the 61st day.

A first step in discharge planning for many patients is therefore the change in their legal status from involuntary to informal. An informal patient can discharge him or herself at any time. Policy requires that a physician complete a discharge report for the patient. If the physician believes that the patient should continue to stay in the Hospital for continued treatment, but is not certifiable, then he or she would note the discharge as being "against medical advice."

Circumstances may arise in which a patient is discharged without necessarily having agreed in advance. The treatment team may believe that no further treatment or care is needed or appropriate. On that basis, the Hospital may be in a position to rescind an informal admission. We would expect this to be done in cooperation with the patient and family whenever possible. We note that the Riverview Hospital's Charter of Patient Rights speaks of a right to "two business days notice" of a discharge (Part 1, s. 17). This provides a minimal form of protection against being suddenly told to leave the Hospital.

The more common issues surrounding discharges from Riverview Hospital involve patients who are anxious to leave, believing they have someplace to go.

A. CONCERNS ABOUT DISCHARGE PLANNING

We heard many stories from families of Riverview Hospital patients about discharges that went wrong. One mother of a son with frequent admissions to Riverview Hospital said that on a recent discharge to a boarding home, the home operator had not been told by the Riverview social worker her son required a bank account near the home to deposit income assistance cheques. No one had assisted her son to open the account. Only when she found out some time later, and accompanied her son to a nearby bank, was he able to access his funds.

"For long-term patients, discharging into the community should not be based so much on the patient's "wellness", rather on whether an appropriate facility is available. Staff have the best knowledge of a patient's specific needs and personality. It's also important to find a placement that normalizes life for its residents as much as possible."
Riverview Social Worker

Another mother said that her son was discharged without an appointment with a Social Services office; the local office then told him he would have to wait over a week for a first appointment. The mother felt her son might not even have pursued the matter had she not stepped in to get an earlier date. Both of these parents stressed that something as simple as a delay, or an extra hurdle getting income assistance, can cause stress and frustration to the newly discharged patient, often inducing relapse.

The spouse of a patient said it seemed as though her husband was "discharged into a void" when he left Riverview. On one occasion, the discharge plan called for him to attend a clubhouse in the community, which turned out only to be in the planning stages. Another time, he had asked to follow-up his treatment with a psychiatrist in private practice, but no arrangements were made. He ended up without psychiatric follow-up from any source, including the local Mental Health Team, for several months.

Parents of a son at Riverview Hospital said they were told his status was informal, so he could leave the Hospital whenever he wished. As a consequence, the social worker suggested little could be done to plan his discharge. The parents pushed to get a few basic arrangements made, including rental of an apartment, but believed this should not have been necessary. Another parent said she was called twice to say her son had been decertified by the Review Panel, and he was waiting to be picked up. No discharge planning had taken place.

Relatives also told us of their shock at finding out that a family member had been discharged from Riverview Hospital without notice to them. Hospital policy says that a letter must be sent to next-of-kin notifying of a patient's discharge, but the letter often arrives days after the patient phones from the community or has arrived at the family home.

"A patient who stabilized in Riverview and has coped in that environment may be unable to cope in the environment of a small community. Yet the system expects aged parents to take over the responsibility at that point."

Mental Health Centre Staff Member

One patient compared two discharges he had from Riverview Hospital. On the first, his Riverview social worker had accompanied him to a boarding house on Vancouver Island; this had helped him stay calm and adjust to the home. The second discharge, two years later, occurred when the patient, on informal status, left the grounds because he was bored and had been told he would have to wait up to two months for a boarding home placement. He left without medications or psychiatric follow-up arrangements, and went to a downtown eastside Vancouver hotel, where he watched television and became increasingly paranoid. He avoided re-hospitalization only because he called his old boarding home, and a staff person came and brought him back.

There are stories of discharges from Riverview Hospital that never got off the ground, that broke down, that narrowly escaped disaster. The reasons are many. They include inadequate planning, the unavailability of services in the community, a patient's frustration with life in the Hospital, failure to support the patient through a time of great stress, and failure of the larger mental health service system to properly support the patient.

Not all of these areas of potential breakdowns in discharge planning are the sole responsibility of Riverview Hospital. Community mental health and social services are not always ready or available to pick up the patient discharged from Hospital. While Riverview Hospital has the primary responsibility to ensure the individual patient's transition to the community goes as smoothly as possible, the overall responsibility is shared. Too often, it appears, the responsibility is not being met.

We believe that Riverview Hospital's first step in addressing this problem is to adopt a policy on discharge planning that makes it clear such planning is of prime importance. The policy should state that the discharge planning commences immediately on the patient's admission to Hospital, subject only to the necessity of dealing with a psychiatric emergency. We note that the Hospital's Charter of Patient Rights refers in Part II, s. 6 to "The right to be involved in discharge planning from the time of admission." We believe there has been a tendency not to begin discharge planning until an involuntary patient's status has been changed to informal. While it may be that a number of discharge issues can go only so far while the patient's mental health remains unstable, it is important that the planning process be underway. This is particularly important given the problem with unexpected discharges resulting from Review Panel orders, discussed later.

Discharge planning policy should also include a list of items that need to be dealt with in every discharge plan. Early in the investigation, the Family Resource Group at Riverview Hospital gave us a draft discharge checklist they were proposing. Their idea was that the responsible social worker would ensure that every item on the checklist received attention in the course of discharge planning. If the item (e.g., housing) had not been addressed, then a written explanation would be required.

Riverview Hospital appointed a Discharge Planning Task Force in the Spring of 1993 to draft new policies and procedures in this area. The Task Force was made up of members of the Family Resource Group, as well as social workers, community mental health staff, and former patients. It delivered its report to the Hospital in early 1994. The definition employed by the Task Force suggests the positive direction required:

> *"Discharge planning is a multifaceted, integrated clinical process that begins at or prior to the time of admission; involves the patient, family, hospital multi-disciplinary team and community service providers; respects both clinical considerations and patient choices; is outcome focused; and has as its intent the discharge of patients to the best situation possible."*

RECOMMENDATION

7-3 That Riverview Hospital adopt policy that sets basic standards for discharge planning, including:

- that the discharge planning process begin as soon as practicable following a patient's admission to the Hospital;
- that the patient be involved at every stage, and that family members be involved, subject to the patient's agreement; and,
- a checklist of items that require attention for every patient; when a patient is discharged without an item having been dealt with, an explanatory note would be written.

We now turn to five specific issues that should form part of on any discharge planning checklist -- money, housing, information, transportation, and advocacy.

■ Money: The Social Services Connection

"A problem occurs when no money accompanies discharged patients. That is, the person who has left Riverview without funds and is not yet linked to Income Assistance. This can mean "slippage" in funding, in which the other facility starts providing home care and housing before any money is available from the rest of the system. Funds should be injected into services as soon as the patient is reintroduced into the community."
Mental Health Centre Director

During our investigation concerns related to money and income assistance became apparent when we spoke to staff and patients at Riverview, community Mental Health Teams and Ministry of Social Services staff. Many problems were encountered by patients who had previously been in receipt of income assistance. When they attempted to get back on income assistance after they had been discharged or left the hospital, they met with roadblocks.

"Patient's package from the Ministry of Social Services should be completed before they are discharged; that includes identification, extra allowances to which they are entitled and the first cheque."
A family Member

A person discharged from Riverview Hospital, who has no other income, will have to apply to the Ministry of Social Services for either handicapped or regular income assistance. The major difference between regular income assistance and handicapped benefits is the amount of money a person receives -- the handicapped rate pays more.

At present, to qualify for handicapped status, a person must:

- have a permanent physical or mental disability;
- not be trainable for employment; and,
- face extraordinary costs of care or supervision associated with the disability.

Again, where a discharge is planned, a number of things are or should be done to smooth the process of applying or re-applying for benefits. If the patient is leaving the Lower Mainland, the Coquitlam District Office of the Ministry of Social Services can work with the Riverview Hospital social worker to have the person make the application at the destination office. If the patient is going to a Lower Mainland location, the Riverview social worker may take the patient directly to the local office. At the very least, an appointment should be made for the patient.

Serious problems arise with unplanned discharges. The patient often ends up on their own without support. If they lack identification, delays can occur, with all the attendant stress and risks. One of the options that Riverview Hospital could implement would be to issue all patients a letter shortly after admission. The letter would explain the person's circumstances, including the nature of their illness, and the need for medical coverage. This would trigger Financial Assistance Workers in Ministry Offices to treat the case on an emergency basis at the time of discharge. The person might receive the higher unemployable rate quickly, and receive income assistance on the basis of handicapped status.

It was also suggested to us that a funding arrangement at admission be available that would allow a social worker to immediately apply for identification where a patient has none. Presently, patients must pay the fee for obtaining identification, and given the size of the comforts allowance, many are reluctant to do so. On admission, it seems less of a priority than it becomes on discharge.

Another problem that surfaced was the perception that front-line Social Services staff workers are not sensitive to mental illness. The Ministry's income assistance application process asks so many questions that a person may become frustrated and leave empty-handed. In these situations, people end up on the street. Worse, miscommunication between Ministry staff and clients with mental illness can result in confrontation with negative consequences for both.

We found some agreement that it would be beneficial to have a liaison, or transition staff person from the Ministry of Social Services for Riverview Hospital. The transition staff could spend up to half time at the Hospital taking income assistance applications and ensuring the paperwork is complete. Although this person might appropriately be stationed in the Coquitlam District Office for efficiency purposes, he or she would liaise with other District Offices in the Lower Mainland and around the Province. Those offices would be informed as a matter of course when a discharged patient was expected to arrive. Riverview Hospital and the Ministry of Social Services staff both thought that this specialist position could assemble useful educational materials for Ministry of Social Services workers. In order to give the transition position status it should be at Supervisor level within the Ministry of Social Services, and not a line Financial Assistance Worker, in order to have more authority in dealing with a range of offices and issues.

Even with improvements in discharge planning and liaison between Riverview Hospital and the Ministry of Social Services, breakdowns will still occur. The consequences of these breakdowns are hard to overstate. The difficulties any patient experiences in returning to the community are immeasurably worse when starting out without this support, and without money. In addition, there are inevitable costs to re-establishing oneself in the community. For that reason, we believe it important that a fund be established whereby every patient discharged from Riverview Hospital receive $200. This sum is equivalent to the amount paid by GAIN to any recipient preparing for a new job or, in some cases, a job interview. We would not view this amount as an advance on income assistance, or as "income" to be deducted from GAIN benefits. It recognizes the costs of starting a life in the community, and, perhaps more important, the costs to the community of patients arriving without any resources from the Hospital on the streets of towns and cities.

A Vancouver Ministry of Social Services supervisor's experience reflects the critical need for information exchange. Many Riverview patients who arrive at her office are already known to her staff and are usually connected to a local mental health drop-in. The person's income assistance file is re-opened. Problems arise if contact with the mental health team lapses. After a couple of weeks without medication, the person's condition often deteriorates and he or she ends up on the street. She felt the system would work better if there was a continuous exchange of information between the Ministry of Social Services and Riverview Hospital about the former patient's situation for a few months after discharge.

There was a consensus among the various staff both from Riverview and outside agencies that it would be a good idea if patients were asked to sign a "release of information" form when discharged from the Hospital. This would allow Ministry of Social Services staff limited access to information from Riverview files that could assist them to better serve their clientele.

RECOMMENDATIONS

7-4 That the Ministry of Social Services create a position for a transition staff person to Riverview Hospital, at a Supervisor level, possibly stationed at the Coquitlam District Office of the Ministry or on the Hospital grounds. Responsibilities would include taking applications for GAIN and GAIN for Handicapped from patients, liaising with Ministry Offices around British Columbia, coordinating the exchange of information where appropriate and preparing educational materials to sensitize Ministry of Social Services staff to the needs of patients returning to their home communities.

7-5 That Riverview Hospital and the Ministry of Social Services develop a protocol to facilitate the exchange of information on patients admitted to and discharged from the Hospital, while respecting patients' rights of confidentiality and privacy.

7-6 That identification necessary to apply for income assistance and other social services be provided and obtained for patients admitted to Riverview Hospital without such identification, either through the creation of a fund to pay the costs of obtaining identification, or by waiving those costs for hospitalized patients, through a coordinated effort by Riverview Hospital and the Ministry of Social Services.

7-7 That Riverview Hospital provide patients (in advance of discharge) with a "letter of introduction" to Ministry of Social Services offices that would contain information needed to open an income assistance file, including employability status if appropriate.

7-8 That the Provincial Government establish a fund to provide a transitional cash payment of up to $200 to discharged patients leaving Riverview Hospital.

■ Housing

Housing is the single most important arrangement for patients leaving Riverview. It is also the most frustrating, for patients and staff alike. There simply are not enough adequate housing opportunities for persons with mental illness in British Columbia.

"He was waiting two and a half months for a boarding home. By the time a boarding home was found, he did not want to leave Riverview because it had become his home. This was too long a wait to return to the community."
A family member

Riverview Hospital social workers repeatedly expressed dissatisfaction with the number and kind of housing placements available to their patients. Many of the larger psychiatric boarding homes built two and three decades ago hold no attraction for younger patients who want more privacy and independence than they provide. Those patients are more interested in semi-independent housing opportunities, where they have their own apartments and share mental health staff support with other residents.

The Mental Health Services Division of the Ministry of Health has succeeded in developing approximately 1500 such opportunities over the past five years, often in partnership with the B.C. Housing Management Commission. More are needed. One interesting recent development at Riverview Hospital has been the use of one of the cottages on the grounds as a half-way house of sorts. The cottage houses a former Riverview patient who did not feel ready to live independently in the community. Staff is provided not by Riverview, but by the Mental Patients' Association that leases the cottage and the Greater Vancouver Mental Health Services Society. This model of transitional housing is being studied to see if it should be available for other discharged patients who may be more vulnerable if they returned immediately to the community.

RECOMMENDATIONS

7-9 That the Provincial Government work with municipalities and the housing development sector to greatly expand the quantity and diversity of low-cost housing options available to persons with mental illness, especially those discharged from Riverview Hospital. Particular emphasis should be placed on expanding semi-independent or interdependent housing opportunities.

7-10 That Riverview Hospital and other relevant authorities study expanding transitional and emergency housing opportunities for discharged patients on Hospital grounds.

■ Information and Communication

"In the hospital, patients do not have the same responsibilities they will meet when living in the community. The kind of information service providers need when a patient returns from the hospital is not so much around medications and psychiatric history, but the individual's coping skills and behavior."

A service provider

We heard many related concerns about breakdowns in communication between community mental health services and Riverview. Riverview Hospital staff often feel that little information from the community accompanies patients on admission, while community workers told us it would assist them to be kept better informed of patients' progress while hospitalized.

One group requiring information is the social workers in the community who will be responsible the discharged patients. A variety of information needs have been expressed. A few of them have been documented in other sections of this Chapter. We will repeat them here:

- the need for access to a patient's file, in order to be informed of the patient's coping skills and behaviors;
- the need for a copy of the discharge plan and related notes; and
- the need for immediate notification when a patient is admitted to and discharged from, the Hospital, especially pertaining to income assistance.

Just as newly admitted patients need orientation to Hospital services and programs, those about to be discharged need re-orientation to the community. It would be useful if information kits were provided to every patient prior to discharge. The kits should contain information on a number of subjects crucial to survival and health in the community. We were shown an example of a package of this kind developed by a psychiatric boarding home in the municipality of Duncan.

RECOMMENDATION

7-11 That Riverview Hospital provide all patients prior to discharge with an information kit that gives information in plain language on how to live successfully in the community, including:

- medications and side-effects;
- addresses and phone numbers of community mental health and other support services;
- how to obtain identification if lost after discharge; and,
- how to open a bank account and do basic budgeting.

It is difficult to identify the number of discharges from Riverview that fall into the unplanned or "rapid response" category. We sought figures for the number and type of discharges that had occurred over the past three years:

Table 3
Discharges by Program Area

PROGRAM AREA	90-91	91-92	92-93
Acute Assessment & Treatment	369	465	458
Continuing Treatment	156	160	103
Organic Brain Syndrome	19	13	13
Community Psychiatry	98	130	106
Geriatric	184	218	168
Medical-Surgery	16	18	9
TOTAL	**842**	**1004**	**857**

With respect to the reason or type of discharge, the Hospital applied categories largely drawn from the sections of the ***Mental Health Act*** that defined the patient's legal status at the time of discharge -- i.e., involuntary or informal. Interpretation becomes a problem. Some involuntary patients have their status changed to informal just prior to discharge. Others do not, depending solely on administrative convenience. Other available figures related to Review Panel discharges, unauthorized absences, and destination information. In their present state, these do not help determine the quality of planning for discharge. Because of the lack of detailed records, it was difficult to estimate the exact number of planned and unplanned discharges. New statistical categories for discharge data should be kept, so that qualitative issues are easier to identify.

A different way of addressing the question is, how many discharges from Riverview Hospital fall into the "planned" category. The Hospital advised that approximately one-quarter of discharged patients go to licensed residential facilities, in which case the opportunity to do comprehensive planning is available. A further 15% of discharges involve patients' returning to acute care hospitals, who then assume a responsibility for discharge to the community. This leaves as many as 60% of discharges where the conditions for planning are less than optimum. In these cases, the combination of starting discharge planning at or before the time of admission together with a capacity to do rapid response planning is necessary in order to minimize the number of unplanned discharges, with all their attendant human and social costs.

Riverview social workers, particularly those in the Acute Assessment & Treatment Program, made the point that the degree of planning that goes into discharges frequently depends on the willingness of the patient to engage in planning. Patients cannot be moved into a psychiatric boarding home, or any other housing facility, against their will. Matching available community resources to a client willing to utilize them is a challenging task. Patients who are intent on leaving Riverview at an early date often do not want to discuss housing options with a social worker. Long-term Riverview patients in the Continuing Treatment Program present staff with a different problem: many do not want to leave Hospital at all. One social worker involved in discharge planning for this population estimated that as many as 80% are reluctant to consider discharge, and need to have the idea gradually introduced.

C. REVIEW PANEL DISCHARGES

"There should be some pre-planning done on every person appearing before a Review Panel in the event they are released by the Panel."
Community group member

Many people expressed concern that the Review Panel process results in a large number of unplanned discharges, with the consequence being that patients turn up in downtown Vancouver without housing or any form of financial support.

We believe that this concern is exaggerated, simply in terms of numbers. The Review Panels decertify approximately 20% of the Riverview patients who come before them. Review Panel discharges accounted for between 2.5 - 4% of total Riverview discharges in the 1990-1993 period. In 1992, the Review Panels decertified 39 Riverview patients. We think the reaction of a physician at one of the Lower Mainland Mental Health Teams was instructive; after saying that Review Panel discharges presented one of the greater challenges to the orderly delivery of mental health services, he admitted surprise that these discharges were, in fact, so relatively few in number.[21]

[21] We do not mean to suggest that a 20% rate of discharges at Review Panel hearings constitutes an "optimum" rate, and that it would be a matter of concern if the Panels decertified a greater or lesser number of applicants. We simply make the point that an existing perception of the scope of Review Panel activity in patient discharges does not appear to be reflected in the actual number of resulting discharges.

Although the numbers are low, the concern is real. The issue of ensuring optimal discharge planning around Review Panel hearings is a particular challenge to all involved. A hearing does not occur unless the treatment team and the patient disagree about the need for ongoing hospitalization. This itself suggests a less than optimal atmosphere for collaborative planning.

"Staff (especially the physicians) were angry. They did not think my son should be leaving. I was told it was up to me to make arrangements, that I could call the local mental health team."
Mother of a discharged patient

Some individuals expressed concern that Riverview Hospital staff involved in discharge planning adopt the attitude that if patients seek a discharge through the Review Panel, they are on their own with respect to making community arrangements. One patient's mother, quoted on the left, told us that when her son was successful at his case before the Review Panel, the treatment team refused to do anything more than provide one night's medication. We heard that staff are sometimes reluctant to do discharge planning prior to a Review Panel hearing.

This problem represents a minority of cases. A Review Panel Chairperson told us that the social work reports that are submitted to every hearing are generally of high quality, and show that considerable thought has gone into planning. We also understand the frustration of staff who feel that patients who go to a Review Panel often want to leave the Hospital as soon as possible, and refuse to discuss where they are going and what they will do when they get there. Nevertheless, we believe that it should be automatic that discharge planning be done prior to every Review Panel hearing and, if a patient is successful, that an offer be made to the patient to stay at the Hospital for a short time while essential community arrangements are made.

We considered other possible solutions to the unplanned Review Panel discharge. It is difficult to see how the effect of a Panel's decision that a patient is not certifiable could be delayed while arrangements are made. If a person is not certifiable, they have the same rights of free movement as anyone else. We asked whether the Review Panel office should have a social worker position, so that decertified patients could be seen immediately to discuss their plans. While this might be helpful in a few cases, we were told the patient's Riverview social worker is the one most able to make arrangements on short notice.

Hearings are no longer scheduled for Friday afternoons. However, because Panel chairpersons and nominees are part-time, many hearings take place in the early evening, after traditional working hours. This means that discharged patients may leave the Hospital when community services are closed. Again, we believe it important that patients in that circumstance be informed they can remain in Hospital overnight, and will be helped to make arrangements the following day. Having transitional housing on the grounds may allay the decertified patients' fears about remaining in the short term at the Hospital to plan their discharge.

"Staff from Riverview Hospital actually went with a patient for the first few days (that) she spent in the community to ensure her transition went smoothly. When the teams from Riverview Hospital have enough time to do this transitional stage, it results in a beautiful linking between what they like to do in Riverview Hospital and what we like to do in the community. The result of this process leads to a much easier integration into the community."
Community Mental Health Worker

The need for a discharge planning policy at Riverview Hospital that requires planning to begin as soon after admission as practicable, as earlier recommended, is underlined in the case of Review Panel hearings. If at least some part of a discharge plan was in place prior to every hearing, problems related to unexpected decertifications could be alleviated. The goal in this and other areas should be to reduce unplanned discharges to a minimum.

RECOMMENDATIONS

7-15 That Riverview Hospital policy state that every patient who has scheduled a Review Panel hearing be advised that should the Review Panel order them decertified, they are welcome to remain in Hospital on an informal basis while community arrangements are made.

7-16 That the Ministry of Health and Riverview Hospital review ways to improve short-term discharge planning for patients decertified by Review Panel order, including assigning a duty social worker to cover evenings or arrange for Panels to sit only in the daytime.

D. DISCHARGE PLANNING THAT WORKS

Having looked at several problem areas in discharge planning, it is helpful to study a few examples of good discharge planning. Given the controversy that surrounds so many issues related to discharging patients, there is a surprising degree of agreement about how to successfully return an individual to the community from a psychiatric hospital.

■ Bridging Services

A good example of bridging services is a pilot project that linked a Riverview social worker in the Continuing Treatment Program with the Fraser Valley-North Shore Mental Health Centre. The social worker had responsibility for planning the discharges of 25 long-term Riverview patients over a one-year period. The discharges fell within the bed reduction program, and so qualified for transitional funding. This permitted a Riverview nurse to follow each patient into the community placement for the first six days, and one day a month for six months.

Moreover, the social worker provided extensive follow-up for the patients. He accompanied them on repeated visits to prospective boarding homes in the months leading to discharge and then stayed in touch with the patient and staff in the home after the return to the community.

This social worker told of several keys to successful discharge planning:

- having sufficient time (at least a year for long-term patients) to develop and implement a plan;
- concentrating less on the "well-ness" of the patient, than on matching her or his personality and needs to a particular housing situation;
- being able to offer the boarding home operator, and the patient, a rapid, short-term readmission to the patient's "home ward" in the event of recurring illness; and,
- not viewing such readmissions as failures, but as steps one might expect in overall progress towards permanent living in the community.

■ Assertive Case Management

"We believe there should be planning for assertive outreach to discharged patients. From our research, this is the key to success in community placements."
A Family Member

Studies have demonstrated that recidivism among discharged hospital patients can be significantly reduced through Assertive Case Management (ACM) programs. The Psychology Department at Riverview conducted one such study between 1990 and 1992 for a group of 50 Riverview patients who received ACM service. ACM involves intensive follow-up by community-based psychiatric nurses with persons with chronic mental illness who are living on their own. Nurses visit the homes of the individuals daily, checking on their medications and helping with any problems that may cause undue stress. This is a different approach than is taken with most Mental Health Centre clients in British Columbia. For most clients, appointments have to be made for services and treatment at the Centre. If the client does not initiate and keep up the contact, services are not provided. ACM involves relatively small caseloads for nurses, and so has higher initial costs. However, it may be cost-effective in the long run to reduce re-hospitalizations.

One of the keys with ACM and bridging programs is to contact clients shortly after they leave the hospital. We heard many people express concern that it may take two or more weeks for a discharged patient to get a first appointment at a Mental Health Centre. Some Centres will not make appointments for individuals on visit leave from Riverview because they are not yet officially discharged.

Wherever possible there should be bridging programs using the Community Health teams."
A Mental Health Centre staff member

By noting what works, and where problems develop, it is apparent how important the links between Riverview Hospital and community services are to the success of clients leaving the Hospital.

3. COMMUNITY MENTAL HEALTH SERVICES AND RIVERVIEW

A. DESIGNING SERVICES FOR A CONTINUUM OF CARE

Upon discharge from Riverview, most patients are referred to mental health services in the community to which they are moving. In Vancouver and Richmond, the referral is to one of the nine Mental Health Teams operated by the Greater Vancouver Mental Health Society (GVMHS), a non-profit society that contracts with the Ministry of Health for this purpose. Elsewhere, the referral will be to a local Mental Health Centre, operated by the Ministry itself. Under the regionalization initiative of the Provincial Government's "New Directions" program, Mental Health Centres will pass from the direct governance of the Ministry of Health to that of regional Health Boards.

The links between Riverview Hospital and community-based mental health services are crucial to successful individual discharge planning, and to providing clients with a "continuum of care." Repeatedly, we heard many family members, Hospital staff, community workers, and clients, believe that a continuum in mental health care does not actually exist. The gap between institutional life in Riverview and life in the community looks to many like a wide gulf.

"Riverview staff should engage in more exchange programs, in-house training and interaction with community care teams so they have incentives for doing good discharge planning."

Community group member

Over the past several years, the roles of community mental health agencies have changed. For instance, the British Columbia Mental Health Society's responsibility is now limited to managing Riverview Hospital -- not to providing community based mental health services. Riverview Hospital administration and staff therefore, have a limited ability to affect what services exist in the community for discharged patients.

We are not in a position to comment in detail on perceived gaps in the community-based service system. However, we were struck by the consistent recognition that Riverview and community services need to know each other better, communicate better and share in the client's transition between services. Not everyone has the same solutions, of course, nor apportions responsibility in the same way. The following outlines some suggestions for bridging the gaps between services.

Visits by community mental health staff to Riverview wards, and by Riverview staff to Mental Health Centres, are highly beneficial. Staff could visit particular patients before or after discharge, or simply exchange information with other caregivers. The pressures of limited time and resources make it difficult to do this. Unless community staff can see several patients on one visit, their time may not be well spent. Community staff said that they did not always feel welcome to initiate visits to Riverview wards; Riverview staff said that community workers seemed reluctant to come to the Hospital. We believe that administrators in both services need to find ways to encourage collaboration and teamwork, to make those activities more comfortable for staff to undertake to the benefit of those they both serve.[22]

One idea raised during the investigation that is now in place was the formation of a multi-disciplinary transition team in the lower mainland operated jointly by Riverview Hospital and GVMHS. The new transition team is composed of staff members from both organizations. They are charged with a dual mandate of providing assertive follow-up with patients being discharged into the Vancouver/ Richmond area who are at high risk of re-hospitalization (to be facilitated by opening an office in the Downtown Eastside), and of assessing patients for "downsizing" discharge into Vancouver/ Richmond.

It will be important that this project not become a substitute for general exchanges between Hospital and community staff, but a way of promoting them. Such exchanges are needed to address other problems that were raised a number of times: a lack of familiarity by Riverview Hospital staff regarding the nature and availability of community services; an "institutional" attitude toward patient care and rehabilitation prevalent among Hospital staff; and the lack of contact by community staff with patients while in Hospital.

RECOMMENDATIONS

7-17 That the Ministry of Health provide resources to permit, and with Riverview Hospital encourage, visits by Mental Health Centre and Team staff to follow clients recently admitted to Riverview Hospital

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22 A collaborative project between the Broadway South Mental Health Team in Vancouver and Riverview Hospital was cited for its positive results in the recently released paper, "Quality and Cost Services for Individuals with Serious Mental Illnesses in British Columbia Compared to the United States", E. Fuller Torrey, D.A. Bigelow, N. Sladen-Dew (July, 1993). The paper received media coverage for its finding that B.C.'s mental health services rated higher than all U.S. state services in quality and cost-effectiveness. The lack of coordination between psychiatric units in general hospitals and local mental health centres was described as "one of the major deficiencies in the province's mental health system." (p. 10)

and meet with patients who will be discharged to their catchment areas.

7-18 That the Ministry of Health and Riverview Hospital actively explore ways to increase opportunities for staff exchanges between the Hospital and community mental health services.

B. ADVOCACY FOR PATIENTS IN THE COMMUNITY

In this Chapter, we have followed the patient to the point of discharge from Riverview Hospital. We have outlined the many concerns relating to discharge including lack of a continuum of care from Riverview to community-based mental health agencies.

Two recommendations were made with respect to linking patients at Riverview Hospital with consumer advocates in the community during the discharge planning process. We return to the subject of advocacy in greater detail in Chapter Nine. At this point, we want to stress the need for advocacy to be viewed as part of the continuum of service available to patients. Patients being discharged from hospital can easily be forgotten in the community. Support available to them in hospital, including avenues for expressing views and complaints (which this Report is intended to strengthen), may not exist outside its confines.

In Chapter Nine we refer to the Ministry of Health's initiative under the Mental Health Plan to fund consumer and family advocacy around the Province. This is a major development. There are few advocacy resources available to consumers of community services, especially outside the Lower Mainland. We are concerned that many people who live in psychiatric boarding homes, let alone those living on their own, get "lost" in the system without advocacy supports being available.

There is also a problem when organizations funded to develop consumer advocacy are also service providers in their local communities -- operating housing projects, vocational programs, etc. This can create conflicts of interest between service provision and advocacy, despite the best intentions. Like professionals who advocate, these service providers need to address the issue head-on.

We make these points as a form of reminder. While this Report is directed at ensuring Riverview Hospital meets standards of administrative fairness in serving patients, it cannot be forgotten those patients come from and return to community settings. The unsatisfactory situation of many of these individuals has attracted a great deal of media attention. It would be unfortunate if attention was paid only to supporting the voices of individuals when they become hospitalized, and not to helping them be heard closer to home.

CHAPTER EIGHT
A RESPONSIVE RIVERVIEW

In the last Chapters, we looked at four contexts of a patient's experience of Riverview Hospital: legal rights, quality of life issues, therapeutic or treatment issues, and issues related to a patient's transition back into the community from Riverview Hospital. With each, we noted the range and type of concerns of patients and their families. We also noted the mechanisms that are presently available to respond to those concerns.

In this Chapter, we bring the existing mechanisms at Riverview Hospital that respond to complaints and allegations of wrong doing together with new mechanisms discussed in this Report. We do this in order to address two problem areas with respect to administrative fairness at Riverview Hospital:

- the absence of a straightforward, understandable system for responding to clients' complaints; and
- the failure to coordinate complaints-handling activities and ensure that complaints are used to improve Hospital programs and services.

1. LEGAL REVIEW MECHANISMS

In Chapter Four: Legal Rights, two existing legal mechanisms that allow a patient to challenge her or his detention in a mental health facility were reviewed. A patient can make application to the Supreme Court of British Columbia under section 27 of the ***Mental Health Act*** or to a Review Panel under section 21 of the same ***Act***.

Patients rarely challenge their detention by going to court because of the need for legal representation and the associated costs. However, eight hundred and thirty-one applications were made to the Review Panel to challenge detention in 1991 and 1992 combined. Of these, three hundred and seventy-six hearings were convened, the remainder withdrawn or patients decertified and discharged prior to the hearing. In 1991 and 1992, an average of 23.5 % of those patients having Review Panel hearings were discharged. The remaining 76.5 % of applications were not allowed.

Review Panels offer a clear recourse for patients wanting to challenge their detention. Its existence is communicated to all patients and their families upon admission both by the Hospital, and to patients by paralegals from the Mental Health Law Program situated on the Hospital grounds.

In Chapter Four, we drew attention to the absence of any procedural protection for involuntary patients with respect to deemed consent to treatment. We made a recommendation concerning the ***Mental Health Act*** on this question.

2. QUALITY OF LIFE

In the discussion of quality of life issues, the existing internal process for responding to complaints at Riverview Hospital was noted: investigation of alleged incidents of patient abuse by staff members. There are two other mechanisms for handling complaints by patients presently in use.

A. PATIENT SATISFACTION SURVEY

The Community Psychiatry Division has developed a Patient Satisfaction Survey which is used in the Division's two wards: Fernwood Lodge and Brookside. The Patient Satisfaction Survey asks patients to rate and comment on a wide range of programs and services. We understand that feedback has led to changes and improvements in both. This approach to receiving consumer input is being extended to other major Program areas, and may become a regular activity every several months. The Hospital has adopted a standardized Patient Satisfaction Survey for mailing to every patient post-discharge, starting in the fall of 1993. This is a positive step that enhances the idea of the patient as a "customer" of the Hospital's services.

B. COMPLAINTS TO HOSPITAL STAFF BY PATIENTS

The standard approach by patients and family members at Riverview Hospital to forward complaints has been the simplest -- communicating complaints directly to staff members. Some parts of the Hospital's operations, such as dietary services, are more used to dealing directly with individual complaints than others. Nevertheless, we would expect that throughout the Hospital it is not, and should not be, uncommon for patients to speak to staff members about problems in programs and services.

However, the process that follows receipt of a complaint has never been clear or formalized. The staff member may or may not attempt to communicate the concern to the appropriate department, or advise the patient who to see. Rarely are complaints written, and rarely do they receive written responses. Because of the lack of formality associated with quality of life issues, a patient cannot rely on, or refer to, approved steps to ensure that her or his concern has been adequately addressed. Many concerns may simply be ignored.

This has also been a problem for patient collective advocacy, which is discussed in the next Chapter. This form of advocacy is primarily directed at quality of life issues that affect all, or many patients. Ward meetings are one way in which concerns of this type can be aired, but as we note later, these have not been developed to the point they might be. A lack of communications protocol between the Patient Empowerment Society (the patients' self-advocacy body at Riverview Hospital discussed in detail in Chapter 9), and Riverview's staff and administration, caused breakdowns in the past. The protocol in place for the last eight months appears to be working.

C. PROPOSED "QUALITY OF LIFE" COMPLAINTS MECHANISMS

The discussion in Chapter Five raised one important area. Riverview Hospital must be receptive to patient complaints in the use of restraint measures and restrictions on privileges. That the Hospital needs a process which permits inquiry into the appropriateness of these measures, and reduce the patient's experience of restraint as an arbitrary decision of treatment team members is clear. The process might be assimilated with other response mechanisms, particularly those developed for alleged violations of the Hospital's Charter of Patient Rights.

3. TREATMENT REVIEW MECHANISMS

In Chapter Six, the types of concerns patients and families have about treatment matters were identified. Several formal internal processes that Riverview Hospital's clinical personnel employ to provide degrees of quality assurance in treatment decision-making were discussed.

The need for patient-initiated processes for reviewing treatment issues were also examined. Involuntary patients may or may not have legal control over their own treatment. That makes it incumbent on Riverview Hospital to provide accessible avenues for complaint in this area. Such recourse is also important for informal, or voluntary, patients. While they

retain the right to refuse treatment, they may sometimes find themselves in a "take it or leave it" position, with the treatment team implying that if a patient does not like a proposed treatment plan, the option is to leave the Hospital or become certified.

At present, there is one recognized mechanism for a patient who wants to make a complaint about treatment to someone outside the treatment team. The process involves submission of the complaint to the Vice-President of Medical and Academic Affairs/Clinical Director. The Vice-President, a psychiatrist, forwards the complaint to the appropriate Program Director, who is expected to meet with the patient and the attending psychiatrist in an attempt to resolve the concern. If a resolution is not reached, the complaint is returned to the Vice-President for further review and decision. The patient receives a written response giving the outcome of the review. A meeting between the Vice-President and the patient will not necessarily occur. In our experience handling Riverview Hospital complaints, few patients seem aware that they can raise concerns about medications and other treatment issues in this way.

In principle, this process provides an avenue of redress for patients. It has not, however, been adequately publicized to patients and family members. It is not part of any written Hospital policy. The process has been informal, and without adequate detail of reporting responsibilities.

Chapter Six, outlined two particular areas in which recourses should be available to patients:

- a request to change caregivers; and
- a request for a second opinion.

With respect to the latter, a recommendation was directed to the Ministry of Health as well as Riverview Hospital because of an anticipated need for additional resources or fee schedule changes to accommodate these requests. We noted that both of these matters are contained in the Hospital's Charter of Rights, which emphasizes the need to find ways to honour these forms of patient-initiated reviews of treatment decisions.

4. DISCHARGE REVIEW MECHANISMS

The discussion of transition and discharge issues in Chapter Seven did not touch on complaint processes that would be unique to these issues. The point is that whatever processes exist or will be created should recognize the continuity of mental health service of which Riverview Hospital plays an important part. Where appropriate, those processes should bridge the patient's transition from and to the community.

There is, of course, a limit to the responsibility which Riverview Hospital owes to patients it has discharged. Nevertheless, complaint processes should be available to individuals so long as they have formal connection with the Hospital, such as being on visit leave, or with respect to a matter that arose during the time of their admission to the Hospital. Processes developed at Riverview for responding to patients' and family members' concerns might serve as a model for similar programs that might be designed for community-based and regionalized mental health services.

We also discussed in Chapter Seven the usefulness of peer advocacy and support in discharge planning. In the next Chapter, we return to the role that consumer advocates might play in easing the transition from Hospital to community life.

5. A COORDINATED APPROACH TO COMPLAINTS HANDLING

Chapter Two touched on the demands which administrative fairness makes on public authorities such as Riverview Hospital. Where an authority is engaged in providing services and programs, fairness requires that it have in place a system for responding seriously to complaints and concerns raised by the people it serves. Where the authority has the power to make decisions that affect the rights and privileges of individuals, fairness requires that it follow procedures that ensure appropriate degrees of openness and consistency in its decision-making.

A. DEVELOPING A COMPLAINTS POLICY

Riverview Hospital, its administration and staff, are primarily engaged in providing mental health services. In certain areas, they also exercise decision-making powers with serious consequences for the people served. The first requirement of administrative fairness is that the Hospital have in place an effective complaints-handling process. To date, that has not been the case.

Most of the internal processes reviewed have been informal, largely based on verbal exchanges, and have not been adequately publicized to patients or families. Several important areas of concern have not been recognized as requiring response processes. Further, Riverview Hospital has not had any system to coordinate complaints and responses. This means that few if any records have been kept on the number of complaints made, on the nature of complaints, on responses made or whether steps were taken as a consequence of a complaint to improve policies or services. The link

between expressions of dissatisfaction by the clients of Riverview Hospital's services, and quality improvement in those services has not been made. Altogether, this situation has reflected and reinforced the perception of the Hospital as an unresponsive and insensitive institution.

The first recommendation in this area, therefore, is that Riverview Hospital adopt a policy on a complaints-handling process. Features of a fair process would include the following:

- the policy states that the Hospital recognizes the value of feedback and complaints, and welcomes both;
- the policy outline the means by which the process will ensure accessibility to patients, including assistance by staff in making complaints for those with limited literacy or English language skills;
- a simple process to initiate the complaint, likely through the use of a plain and understandable form for making a complaint, and a clear procedure for noting a complaint made orally or by telephone;
- assignment of investigative responsibility to an appropriate level in the organization, and to a person sufficiently independent from the circumstances giving rise to the complaint;
- written acknowledgment of receipt of a complaint, and written response at the conclusion of investigation;
- reasonable timelines for response;
- provision for an appeal to the President of the Hospital, or possibly a Board of Trustees committee where the complaint is not substantiated; and,
- the publication of the complaints policy and process through plain language brochures, orientation to new patients and families, and by staff asking patients if they wish to make a complaint when an issue arises.

Not every mention of a problem by a patient needs to go through a formalized process of this kind. Staff members, however, should be familiar with the policy and encourage its use. When a patient raises an issue with a staff member, it would be appropriate for that staff member to seek a resolution on an informal basis. If such a resolution is not possible, or the issue has significance beyond the individual's situation, staff should encourage a formal complaint. A means by which staff can file a complaint on behalf of a patient, anonymously if necessary, should be in place.

RECOMMENDATION

8-1 That Riverview Hospital adopt a policy on complaints that incorporates the principles of administrative fairness, including accessibility, simplicity, investigative responsibility that is

independent, written acknowledgment and response, a third party complaints process and an internal appeal.

B. A VARIETY OF PROCESSES

We recommend a complaints policy that would introduce uniformity regarding how complaints are received. There are, however, a number of different issues that require a variety of responses by the Hospital. We point, for examples, to the following:

- Requests for change of care-giver, or for a second opinion;
  We have recommended that, in accord with the Hospital's Charter of Patient Rights, processes be found to permit a minimum number of times that these requests can be made over a specified time period.
- Complaints about violations of the Hospital's Charter of Patient Rights, or incidents of restraint and denial of privileges;
  These matters will often require factual investigation, and then a decision with respect to whether the facts reveal a violation of policy, or poor exercise of judgment. Decisions should be made with consistency, and only after hearing from the complainant.
- The refusal of a competent involuntary patient to consent to proposed psychiatric treatment;
  We have recommended that this give rise to a form of hearing before the Director or person delegated by the Director.

There will continue, therefore, to be a range of internal processes that respond to the different issues that may give rise to a complaint. These may be more or less formal, ranging from discussion to the point of requiring a hearing depending on the significance of the rights or privileges involved and the nature of the allegations. An important role in the Hospital's complaints procedure will be ensuring that complaints are referred to the appropriate internal process.

C. PATIENT RELATIONS COORDINATOR POSITION

The responsibilities of Riverview Hospital outlined in the foregoing discussion have the potential to significantly change the culture of the Hospital. They also have the potential to introduce an undesirable complexity to Hospital programs if they are not coordinated at a high level in the organization. These reasons, in our opinion, justify the creation of a new position at Riverview Hospital. We term this position the "Patient Relations Coordinator."

The Coordinator should play an important role in establishing a comprehensive complaints handling system at Riverview, in familiarizing staff, patients and the public with its operation, and in assisting with its operation. The detailed responsibilities of this position need to be developed by Riverview Hospital in consultation with client groups. Below are parameters which might guide the design of this position.

- **Statement of Philosophy**

We suggest that Riverview focus and direct the PRC to give priority to acting fairly. In order to achieve that, the PRC should be guided by a Statement of Philosophy that emphasizes a patient-centred approach. The basis for this Statement could be derived from the Hospital's own Mission Statement, the Principles set out in this Report, and the Hospital's Charter of Patient Rights.

- **Responsibilities**

(a) Refer Complaints to the Appropriate Internal Process

A number of internal avenues may exist for investigating and responding to individual complaint matters. It will be important that complaints be referred to the appropriate process. A principle function of the PRC will be to monitor the intake of complaints, and ensure each is going to the appropriate place.

(b) Coordinate Complaint Investigation in Specified Areas

This Report has identified a few sensitive areas for complaints-handling, including some that will be new to Riverview Hospital. We believe two of these will require particular attention on the part of Hospital administration. The first involves allegations of a violation of the Hospital's Charter of Patient Rights. In many cases, these will call for investigation of a particular set of facts, and then application of the factual findings to an evolving, patient-centered interpretation of the document itself. In other cases, a Hospital policy or practice may be challenged using the Charter.

The second sensitive area for investigation involves complaints about restraint measures or restriction of privileges. In earlier discussion of these complaints, we suggested investigations might be done under the Patient Abuse policy, or through a form of treatment review. It will be important that the appropriate approach is used in individual cases, and that fairness and equity are reflected in the outcomes of both processes.

The PRC position can make an important contribution by monitoring and giving advice on the handling of complaints in these two areas. In particular, the PRC could take the lead role in developing the overall administration's interpretation of the Hospital's Charter of Patient Rights. It may be that the PRC should assume an investigative role in some cases, or be brought in to decide the outcome of a complaint following an investigation. We leave those matters open at this time.

(c) Maintain Records of Ward Meetings and Monitor Ward Meeting Standards

Chapter Nine discussed ward meetings at Riverview Hospital and mentioned the need for meeting minutes to be kept with copies forwarded to a central location. It may be an appropriate role for the PRC to receive and watch for issues being raised in the minutes, as well as to assist in developing ward meetings as useful forums for patient input.

(d) Collect Data on Complaints, Responses, and Outcomes

The coordination of complaints information and statistics is an important aspect of fairness. It is necessary to use complaints information to improve services, rather than merely dispose of them as individual problems. The PRC should take this on as a principle function.

(e) Reporting Function and Advice on Policy Issues

Effective reporting of complaints data is as important as collecting the data on complaints and resolutions. Therefore, the PRC should report on a regular basis to the Board of Trustees of BCMHS, both in person at Board meetings, and in regular, written reports. The reports would contain statistical information on complaints and outcomes as well as highlight policy and procedure issues raised. Further, the PRC should report on other activities undertaken, and identify any institutional barriers that prevent the implementation of patient-centered initiatives at Riverview Hospital.

(f) Liaison with Office of the Ombudsman

The PRC would serve as the principle contact point between Riverview Hospital and the Office of the Ombudsman. In that role, the PRC would receive complaints referred by the Ombudsman for internal investigation and reporting back, where the Ombudsman exercised her discretion not to undertake the initial investigation. The Ombudsman has sought to develop similar protocols with many of the authorities within the Office's jurisdiction, both to facilitate investigations and to assist authorities in assuming a front-line responsibility to their clients.

In addition, representatives from the Office of the Ombudsman could be available to work with the PRC in developing interpretations of the Hospital's Charter of Patient Rights, and applying them to individual situations. The Ombudsman will, of course, follow with interest the implementation of measures related to recommendations contained in this Report, and would anticipate working with the PRC in that regard.

This is not intended as an exhaustive list of responsibilities for a Patient Relations Coordinator position. Indeed, in subsequent chapters which deal with advocacy by and on behalf of patients, reference is made to responsibilities on the part of Riverview Hospital, some of which might be assigned to the PRC.

■ **Accountability**

The Patient Relations Coordinator should be directly accountable to the President and Chief Executive Officer of Riverview Hospital and the BCMHS Board of Trustees.

■ **Appointment**

Riverview Hospital should seek the input of patients, PES, the Family Resource Group, and consumer advocacy organizations, when selecting the criteria for the Patient Relations Coordinator position(s). Consideration should be given to including in those criteria for job selection experience as a consumer, family member of a consumer, or as a community advocate.

RECOMMENDATIONS

8-2 That Riverview Hospital create a senior administrative position of a Patient Relations Coordinator (PRC) to assume responsibilities for coordinating the complaints-handling process at Riverview Hospital, including but not limited to:

- monitoring and supporting policies and processes that are intended to expand the participation of and communication with patients and family members in Hospital activities, (such as ward meetings and implementation of the Hospital's Charter of Patient Rights);
- reporting regularly to the Board of BCMHS on results, problems, and opportunities in the PRC's areas of responsibility; and,

- acting as liaison with the Office of the Ombudsman and any other external agencies with respect to patient complaints matters.

8-3 That Riverview Hospital develop a "How to Complain", or "How to Be Heard" brochure for patients and families that outlines, in plain language, how a patient can make a complaint. Included should be examples of the types of complaints that can be made, and how complaints are responded to, as well as referring to available sources of advocacy support.

In January 1994, Riverview Hospital adopted a "Service Feedback from Patients/Citizens" Policy that addresses a number of the issues and recommendations raised in the foregoing discussion. A job description for the "Coordinator of Patient Relations" referred to in the Policy has been drafted. We congratulate the Hospital for having moved ahead with initiatives in this area, and look forward to working with and monitoring their implementation in accordance with our recommendations. The Policy is reproduced as Appendix II to the Report.

6. SUMMARY

This Chapter endeavoured to summarize the internal response mechanisms which do or should exist at Riverview Hospital in order to meet a standard of administrative fairness. We have recommended that an overall complaints policy be adopted, and that it be coordinated through the creation of a Patient Relations Coordinator position at the Hospital.

What has been described here are processes and positions which are internal to Riverview Hospital, and subject to its ordinary systems of administrative control. It is important to realize that what we have outlined is not a form of *advocacy*, but rather of institutional and administrative responsiveness to individuals served. In the next Chapter, we discuss the nature of advocacy, as well as existing and proposed sources of advocacy to support patients.

Riverview Hospital remains accountable for the internal response processes it develops to external bodies, principally the Office of the Ombudsman. For that reason, we will conclude this Chapter with a brief discussion of the Ombudsman's role *vis-à-vis* Riverview and other hospitals in British Columbia.

7. OMBUDSMAN OF BRITISH COLUMBIA

The Ombudsman of British Columbia. operates under the authority of the ***Ombudsman Act***, RSBC 1979, c. 306. Section 10 of the ***Act*** states that the Ombudsman may "on a complaint or on her own initiative" investigate actions of Provincial government authorities "with respect to [matters] of administration." The statute provides the Ombudsman with wide investigative powers, including the right to enter government premises, require production of documents, and obtain information from any present or former employees of the authority in question. During or at the conclusion of an investigation, the Ombudsman can attempt to settle an individual complaint, or recommend that the authority take certain steps, or change its procedures or a decision it has taken. The Ombudsman cannot order that those things be done.

The Ombudsman's Office has exercised this general jurisdiction with respect to Riverview Hospital since the appointment of the first Ombudsman in 1979. That has usually involved acting on individual complaints received from patients, family members and acquaintances of patients. The Ombudsman has also initiated complaints into more systemic issues, such as the present investigation into channels for complaints-handling and patient advocacy at Riverview. Ombudsman investigators visit wards at Riverview, and also take complaints over the telephone. Since the Summer of 1992, the Ombudsman has had access to office space in East Lawn to facilitate its work at Riverview and this Report.

The range of complaints that the Office has dealt with at Riverview is broad. It includes complaints about food services, the handling of patient accounts, seclusion incidents, and allegations of abuse of patients by staff. The Ombudsman does not deal with involuntary patients' requests to be discharged, a legal matter, nor with issues of clinical treatment, as those are not administrative in nature. The Ombudsman will, however, bring concerns about treatment to Hospital staff, and look at the responsiveness of the Hospital to these concerns.

The Office of the Ombudsman is not an advocate for complainants in the sense of taking instructions and seeking to obtain the objectives or outcomes they are pursuing. Rather, the Ombudsman serves an impartial investigative function, by looking into the facts of particular situations and making recommendations aimed at achieving fair and balanced resolutions for the interested parties. Indeed, the general mandate of the Ombudsman is to promote administrative fairness in the provision of public services.

The Ombudsman will continue to exercise this jurisdiction with respect to Riverview Hospital notwithstanding that the recommendations of this Report may be adopted. The recommendations propose an expansion in advocacy services for consumers of mental health services, and further internal response mechanisms within Riverview's administrative structure. These changes are intended to result in more systemic fairness to patients, their families and advocates.

In the Spring of 1993, the jurisdiction of the Ombudsman was extended to cover all general hospitals in the Province. Our Office has been engaged in assisting hospitals to develop complaints-handling mechanisms and protocols. We believe that the proposed position of a Patient Relations Coordinator at Riverview would be consistent with approaches being taken by other hospitals and assist the Ombudsman in meeting her investigative responsibilities. To the extent this report makes recommendations which go beyond protocols which may be worked out with general hospitals, we believe that reflects the particular vulnerability of hospitalized psychiatric patients discussed earlier in the report.

In the course of this investigation, we became aware of one potential barrier to the exercise of the Ombudsman's jurisdiction with Riverview and other hospitals. Section 57 of the British Columbia ***Evidence Act*** protects consultant reports prepared by medical professionals about other medical professionals for hospital quality assurance committees from disclosure. The purpose of section 57 is to permit hospitals to obtain analyses of internal clinical practices in confidence. The absence of confidentiality may serve as a deterrent to obtaining such analyses. The problem is that section 57 arguably prevents disclosure of these reports to the Ombudsman. We believe in certain circumstances this could hamper the investigation of a complaint, which itself is subject to statutory obligations of confidentiality. The last recommendation in this section seems to clarify this matter in a balanced way.

RECOMMENDATION

8-4 That the Attorney General table an amendment to the ***Ombudsman Act*** or the ***Evidence Act*** as soon as possible to create a specific exception to section 57 of the ***Evidence Act*** for the purpose of Ombudsman investigations making clear that release of the report to the Ombudsman does not waive the privilege provided to hospitals by section 57.

CHAPTER NINE
EXISTING ADVOCACY RESOURCES

In the preceding five Chapters, we looked at many of the concerns that patients, former patients, and family members have with respect to Riverview Hospital. We also examined the various mechanisms and review processes that are or should be available to respond to those concerns. For the next two Chapters, we turn to the subject of advocacy.

Why is advocacy important? For vulnerable persons in our society, like patients in a psychiatric hospital, it may not be enough to have processes that respond to concerns or complaints. It may be necessary to support them by ensuring they are listened and responded to. That is what advocacy involves: maximizing participation.

There is a second reason why advocacy is important: to help Riverview Hospital make the cultural transition from a large institution that has relied in the past on the imbalance of power between Hospital staff and patients to get things done, to a patient-centered facility that employs a greater degree of respect for and cooperation with those it serves. This is a major paradigm shift. It will not always be easy for long time administrators and staff, used to doing things in certain ways, to make the adjustment. The internal processes reviewed in Chapter Eight can make a difference in attitude. Still, leadership and advocacy inside, and from outside the Hospital, are essential.

Most often the most effective advocacy is self-advocacy. A self-advocate achieves two things:

- having his or her deepest needs and wants respected; and,
- attaining a degree of healthy autonomy.

In general, hospitalized mental patients fare poorly in both areas. Enabling, developing and supporting patients as self-advocates should be a leading objective of mental health services.

The patient as a self-advocate is a first principle. A hospital that is welcoming and responsive to the complaints of patients through mechanisms already discussed will go a long way to providing opportunities for self-advocacy. This Chapter focuses on other sources of advocacy, other than self-advocacy, that are needed to enable this

vulnerable population to participate and be heard.

What is advocacy? During the course of this investigation, the work by the Advocacy Project Team, a task force initiated by Riverview Hospital was undertaken and completed. The Team was comprised of Hospital staff members, representatives of community organizations, consumers of mental health services, and present Hospital patients. In November 1993, in the late stages of our investigation, the Team released its findings in a document titled "A Framework for Advocacy at Riverview Hospital." The discussion and recommendations of the "Framework" coincide with those contained in this Report. For a definition of "advocacy", we quote from "A Framework for Advocacy at Riverview Hospital":

> *"Advocacy is a process by which a person or individual acting on someone else's behalf makes representation regarding rights, privileges, benefits and other issues pertinent to persons with a mental health problem. Advocacy on behalf of others is based on the individual's instructions, is respectful of the individual's rights and values, and maximizes the involvement of the individual."*

For people with a mental illness, advocacy serves as a "ramp" to inclusion and participation. Fairness requires that appropriate supports and services are available to patients so they are being heard. Advocacy supports and services are the means to achieve that goal.

1. PERSPECTIVES ON ADVOCACY

Advocacy can be looked at from a number of different perspectives. In this section, we outline four perspectives. Each reflects the importance of the respective roles, responsibilities, and powers of people (or agencies) that are engaged in advocacy-related activities. Reviewing these perspectives or questions may assist to identify gaps in advocacy, and in designing supports for advocacy.

- Is the advocate concerned with problems of an individual or a group? (Is it individual or systemic advocacy?)
- What type of cases/issues does the advocate address? (Quality of life, treatment, transition or legal issues?)
- To whom is the advocate accountable? (Internal or external accountability?)
- Who is the advocate? What relationship does the advocate have with the individual or group? (Natural or professional?)

■ Is the advocate directed at problems of an individual or a group?

Is the advocacy directed at problems of individuals, or broader system or policy issues that concern a whole group of people? Different considerations apply to each. The most significant considerations are "instruction" and confidentiality. "Instruction", means that advocates generally act on the instructions, or directions, of those on whose behalf they advocate. If the advocate deals with the problems of an individual, direction would usually be sought from that individual. Group or systemic advocacy, however, raises a question of representativeness: How does the "group" give directions that represent its collective wishes?

An advocate acting for an individual is also likely to need confidential information about the individual. The advocate, then, needs to obtain legal authority to request confidential information -- as the institution would require it before allowing access. Advocacy on group issues less frequently raises issues of confidentiality. An advocate might do both individual and systemic advocacy. For instance, advocacy for individual patients may reveal issues that have implications for an entire group of patients.

■ **What type of cases does the advocate address?**

In the mental hospital setting, the subject matters for advocacy could be classified in much the same way as the Chapters of this Report: legal, quality of life, therapeutic, and transitional or discharge matters. Each of these subject areas makes its own unique demands on the style and design of advocacy.

For instance, legal advocacy generally involves strict adherence to the instructions of individual clients, and the tailoring of presentations to the technical requirements of rule-bound decision-makers, like courts or Review Panels. Quality of life issues are likely the most amenable to advocacy by patients themselves, on their own or as a collective, because they rarely need to be tailored to fit the specialized languages of law or medicine. Advocacy on therapeutic issues is likely to call for a degree of familiarity with clinical issues. Advocacy on transitional issues, like discharge planning, might work best if it was available to patients both in hospital and in the community.

■ **To whom is the advocate responsible?**

In other terms: Is the advocate accountable to the entity the advocacy is directed "against", or to an external source? Does the advocate receive funding or managerial direction from an internal or external source? For present purposes, is the advocate internal to Riverview Hospital and subject to its overall direction, or is it external to the Hospital's management structure?

In general, it is unusual to have advocacy accountable to the very institution that is the subject of its activity. Advocacy has an adversarial component (even if the best advocacy seeks cooperation when possible). It is hard to have the creative tension produced by good advocacy if the advocate and "adversary" answer to the same authority. For this reason we believe advocacy resources should be independent of Riverview Hospital. If government funding is needed to support advocacy, it may be necessary to insulate the advocacy from the funding source.

It may be, however, that certain processes are mislabelled if called "advocacy." Client-centred response mechanisms that are internal to an institution like Riverview Hospital should be understood in that light.

- **What relationship does the advocate have with the individual or group whose interests are being represented? Who is the advocate? Is the advocacy being done as a result of a professional or natural relationship?**

We have organized the sections of this Chapter with relationships in mind. For each source of advocacy available to Riverview patients, we look at their roles, the type of subject matter that the advocate may address, the accountability of the advocate and the nature of advocacy -- whether it is true advocacy or an investigative process.

Each advocate faces different challenges, and meets with varying degrees of success. We hope to clarify the appropriate role for each, and identify barriers that have prevented them from working as effectively as they might have in the past. We then look at gaps in the advocacy system and make proposals for closing those gaps.

2. INFORMAL OR NATURAL ADVOCACY

"Informal or natural advocacy" refers to advocacy performed as a natural outgrowth of personal experience, relationships or closeness to the subject of the advocacy. Natural advocates often have little or no legal recognition as advocates, and do not get paid to be advocates. They are usually the most powerful advocates of all, because of the knowledge and motivation they bring to the task. It is intended that recommendations made in this Chapter would enhance the effectiveness and recognition of informal advocates.

There are three groups in this position; families of patients,[23] staff members and administrators, and former patients. This section looks at the role of families, staff, the BCMHS Board of Trustees and consumer groups, all potential informal advocates for patients.

A. FAMILY AS ADVOCATES

Family members -- parents, children, spouses, siblings -- of patients are often their most important advocates. During this investigation, we were repeatedly struck with the depth of commitment, thoughtfulness, and common sense displayed by the family members we met. As parents, many have experienced a great deal of emotional pain over the years. Many have overcome the challenges. They know every frustration the mental health system can deliver; they also recognize and respect the work of dedicated mental health workers and professionals. Family members know that in many instances, they remain the one constant in a life that may experience repeated admissions to hospitals, stays at boarding homes, and relationships with various mental health teams.

What families provide to patients, given by few others, is a dogged determination to see that family member's therapeutic interests are served and respected. The family has something that few professionals do; a relationship with the person based on love, affection and experience dating back before the onset or diagnosis of the illness. This permits family advocates to know and better appreciate a patient's all-round needs.

[23] We include friends of patients with family, although there may be different considerations for friends with respect to confidentiality of patient information.

The importance of family advocates of persons with mental handicaps has been displayed in recent years. British Columbia and many parts of Canada have seen a remarkable move to the deinstitutionalization and integration of persons with mental handicaps into society. Each step of the way, individual families and organizations of families have pushed and prodded government services to become more open, inclusive and creative. We heard this sentiment from a number of people; "If families of persons with mental illness had the same influence as families of people who are mentally handicapped, the mental health system would be much further ahead than it is."

There are reasons why this influence has not been greater. Most important, perhaps, has been the blame and shame that surrounded families with mentally ill members in past years. For several decades, influential schools of thought attributed illnesses such as schizophrenia as acquired due to parental actions or inactions. The theories held that dysfunction in families caused stresses that resulted in breakdowns. Professionals treated families as part of the problem rather than part of the solution. This was not the case for people with a mental handicap. Partly as a consequence, families frequently absented themselves from the lives of institutionalized relatives or were discounted by professionals. Not unlike for persons with a mental handicap but in their case it was the sense of hopelessness promoted by professionals.

This situation has changed dramatically. Advances in research that have shown biochemical causes of major mental illnesses have helped reduce the blame and shame phenomenon. Families, through organizations like the British Columbia Schizophrenia Society, are now much more actively involved in mental health issues than before. The Ministry of Health and Riverview Hospital have both had to adjust to this new reality.

They have done so in a number of ways. The Mental Health Initiative established a goal of a minimum one-third consumer participation on all boards or committees involved in the delivery of mental health services in the Province. "Consumers" are defined to include "families of persons with mental illness."

This goal was supported with funding, which resulted in family participation at a number of levels in the system. As part of fulfilling the Initiative, the Ministry of Health appointed a Family Advisory Council in 1992. The Council is charged with advising on and directing Ministry and regional spending on family involvement programs in mental health. The Council meets on a monthly basis.

Riverview Hospital has also taken steps to strengthen family advocacy. A social worker was assigned to facilitate the Family Resource Group (FRG), which provides a forum for interested relatives to speak on Hospital issues. The FRG meets monthly in an office designated for its use. Orientation sessions are offered by the FRG to "new" families. One Family Resource Group member sits on each project team involved in planning bed closures of the five Program areas. Riverview also offers accommodation to families visiting from outside the Lower Mainland in a cottage on the Hospital grounds. Nevertheless, family members told us that they still do not feel comfortable at Riverview Hospital, that their voices do not have enough influence. In 1990, the Social Work Department at Riverview produced a study, "What Families Want From Riverview: A Look At The Concerns Of Families With A Mentally Ill Relative."[24] This study revealed many of the same concerns expressed in interviews. The main concerns were:

- Communications -- a widespread feeling that contacts with treatment team members occur only at the initiation of family members, that regular reports on a relative's condition are not made, and major changes in medications, legal status or planning for discharge occur without notice to families;[25]

- Quality of care -- concerns that patients are not engaged in enough activities, that facilities are uncomfortable and lack privacy, and that little interaction takes place between staff and patients on some wards;

- Lack of support -- unmet needs of many family members for more information on mental illness, medications and Hospital programs, and for counselling to assist with the stress of having a hospitalized relative.

If family members are to be encouraged to stay in touch with and advocate on behalf of their relatives, they require information to help redress the imbalance that exists in their communication with professionals and treatment team members. Specifically, they need to know that they are welcome at Riverview Hospital.

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24 Clarke, Allan; November 13, 1990

25 Riverview Hospital's present "Social Work Policy: Family Contact" states that social workers shall initiate contact to designated family members once every three months for "short stay programs", and once every six months for "long stay programs." Even acknowledging that many family members have more frequent contact due to their own efforts, or an individual patient's circumstances, these minimum periods appear too long and should be reviewed.

RECOMMENDATIONS

9-1 That Riverview Hospital review the recommendations made in "What Families Want From Riverview" dealing with major family concerns to see which still remain to be acted upon and develop an action plan.

9-2 That training be made available to Riverview staff sensitizing them to the needs of family members, and how to respond helpfully to their inquiries, input and comments.

9-3 That procedures be developed to ensure that family members are advised of all significant changes in a patient's care, including medications, physicians, legal status, and decisions to discharge the patient, subject to the patient's rights to limit or refuse disclosure, and that families know who they can contact with questions. This information ought to be provided in the family's orientation package.

9-4 That the present schedule of regular reporting to a patient's family be reviewed for its adequacy, and that families be advised on the admission of a relative of their opportunity to have meetings with the treatment team at regular intervals.

9-5 That Riverview Hospital staff know how to access existing Provincial funds from any and all sources to support family members' travel costs for visits to Riverview Hospital and that they inform family members of these procedures. Where a patient has been served in her or his local community and intends to return, this continuity of natural support provided through visits, is critical.

9-6 That ward and program staff at Riverview Hospital plan more opportunities to include interested family members in patients' activities.

■ Family Advocacy Problems

Potential Conflict of Interest

One problem with family advocacy is the potential for conflict of interest. This is evident on the large scale, where organizations primarily representing or composed of family members have taken positions supporting broad criteria for involuntary committal, and treatment without consent, in opposition to groups made up of and representing mental health consumers. This reflects the fact

that family members and patients do not necessarily share the same views about what is best for the patient. This is not surprising, nor is it wrong. Also, family members often have to be advocates for themselves, and that may lead in a different direction than advocacy that focuses on the wishes of the patient. For this reason, while families need support and encouragement in their role as advocates for patients, their advocacy is not a substitute for patient self-advocacy or self-determination.

Confidentiality

A barrier to the role of family members as advocates are the rules surrounding confidentiality. Medical professionals have an ethical and legal obligation not to disclose clinical or personal information obtained in the course of treating a patient to any third party, without statutory authority or consent of the patient. Therefore, where a patient refuses to give consent to disclosure, or the patient is considered unable to give consent, family members may be prevented from obtaining information that is important to their advocacy.

Riverview Hospital policy on release of patient information reflects this understanding in part. Policy PAT-205 states:

> *"Clinical information may only be released with written consent from the patient or other authorized person(s) acting on the patient's behalf, in accordance with the law, or written hospital policy.*
>
> *If a patient is 19 years of age or older, information about the patient may only be released with express written consent from the patient, or as otherwise stipulated by hospital policy or statutory requirement.*
>
> *Only information as to whether a specific person is or is not a patient of the hospital will be disclosed in response to requests for information about that person, except when a patient expressly requests that this information not be released.*
>
> *The next-of-kin of a patient will be advised of any significant change in that person's condition unless otherwise instructed by the patient or next-of-kin."*

We note several features of the policy. First, it provides for exceptions to the rule. Second, it implies a pro-active duty of medical personnel to inform next-of-kin of changes in condition, presumably even where the patient is considered incapable of consenting to disclosure. However, it is silent with respect to ongoing discussion of treatment matters in that situation. Finally, the policy does not permit any disclosure where the

patient refuses to consent. The question of whether the refusal may be influenced by illness or treatment is not addressed.

We have encountered this latter problem several times in complaints brought to the Ombudsman by family members. The daughter of a patient was told she could not be informed about her mother's treatment, or even of her discharge from Riverview, because the mother had expressly stated she did not want that information disclosed to any family member. The daughter believed this refusal was rooted in her mother's paranoid condition and so should be ignored by Riverview personnel.

In another case, the mother of a patient wanted a non-family member to assist her at a meeting with Hospital officials to discuss treatment issues; the Hospital said that because the patient was deemed incapable of consenting to disclosure, confidential information could not be discussed in front of the non-family member.

Such situations involve a conflict between two important interests. On one hand, there is a desire to involve family members in the care of their loved ones. On the other hand, patients' rights of confidentiality and privacy must be respected. We believe that exceptions cannot be made in respecting those rights just because the setting is a psychiatric facility. Indeed, the kinds of personal issues that arise in psychiatric treatment underline the need to extend the same protections as would exist for patients in a general hospital.

Nevertheless, we believe there are areas related to disclosure where Riverview Hospital could be more supportive of family advocacy, while at the same time respecting confidentiality. One method of supporting family advocates is by establishing the position of Patient Relations Coordinator (PRC). This has been referred to in Chapter Eight with recommendations to involve the PRC in varying types of complaints that may arise at Riverview. We suggest that the PRC also have first-hand responsibilities for resolving appropriate issues regarding family advocacy and access to information.

RECOMMENDATIONS

9-7 That Riverview Hospital staff be available to receive advice, concerns and input from family members, even when a patient has refused to consent to the disclosure of personal information to their family members.

9-8 That family members who are denied information, on the grounds that the patient has refused to permit disclosure, be advised of their ability to make a complaint to the Hospital (PRC) so that the matter can be reviewed.

B. STAFF MEMBERS AS ADVOCATES

A second important source of informal advocacy on behalf of patients is the Hospital staff that works with them on a day-to-day basis. Many patients at Riverview have no remaining close family connections; even those who do, will spend much more of their time with ward nurses and health care workers than with family. Staff also know when treatment problems, or a relationship problem between patients or staff, have arisen. They do not encounter the same barrier of confidentiality that family members do though issues around use of information are likely to arise.

"The primary nurse is the patient's advocate. Individually that is true of nurses, but all staff have an advocacy role. The roles change in certain areas of the hospital. In various programs it could mean different things -- treatment, patient's rights, comfort levels, etc."
A Riverview Hospital Nurse

Many Riverview staff members describe themselves as advocates for their patients. This was said in various contexts. Social workers told us they advocated for patients with respect to discharge planning. Nurses said they viewed their role as advocates for patients, especially in treatment matters. A patient's primary nurse, for example, is expected to raise any concerns the patient has expressed with the treatment team. Nurses also report problems caused by particular medications or dosages.

A senior psychiatrist said that the Hippocratic oath requires physicians to be advocates for patients vis-a-vis hospital services. Doctors tell hospital administrators what a patient needs, and fight to get it. That duty, they say, comes ahead of any owed to the hospital itself.

This role of staff as advocates for patients should be encouraged. For patients with fluctuating or restricted abilities to advocate on their own behalf, staff advocacy may be a crucial safeguard for their interests.

Advocacy by staff depends greatly on the attitude of management; only if the Hospital administration actively supports the advocacy role, and ensures that it is rewarded rather than punished, will it flourish. There are examples of positive developments in this regard. For instance, the "Patient Abuse by Staff" Policy states that staff have an obligation to report any incident that may constitute abuse and that the Hospital has the responsibility to ensure that those who make such reports do not experience repercussions for fulfilling this duty.

An important part of staff members' knowing they have their employer's support is a statement that no retribution against staff who engage in

advocacy on behalf of their clients will be taken, or be tolerated, by the Hospital. A protection against retribution for persons who contact our Office was recently incorporated into the ***Ombudsman Act***:

> *s.15.1 No person shall discharge, suspend, expel, intimidate, coerce, evict, impose any pecuniary or other penalty on or otherwise discriminate against a person because that person complains, gives evidence or otherwise assists in the investigation, inquiry or reporting of a complaint or other proceeding under this Act.*

This protection would, of course, extend to Riverview Hospital staff with respect to communications with the Ombudsman which is one place for staff to safely advocate for patients.

An example of the type of step taken by a government authority to support its employees in assuming an advocacy role is given by the Ministry of Social Services, which recently circulated a letter to Ministry front line financial assistance and social workers confirming its support for advocacy.

RECOMMENDATIONS

9-9 That Riverview Hospital administration develop a specific policy outlining the role of staff as front-line advocates and confirm the Hospital's present understanding that retribution of staff for participation in advocacy efforts will not be tolerated.

9-10 That Riverview Hospital include in its orientation materials an explanation regarding the protection against retribution for contacting the Ombudsman as provided for in the ***Ombudsman Act.***

9-11 That Riverview Hospital adopt a policy that expressly authorizes staff members to refer patients to available formal advocates.

Being an advocate for patients should not result in staff "spying" on each other. It should result in a more patient-centered approach to psychiatric care. That approach is one of the basic principles of "Total Quality Management." Riverview, like many other hospitals in British Columbia and across North America, has adopted this management philosophy. We frequently heard staff say that for years, Riverview Hospital has had a directive, hierarchical, style of decision-making which excluded front-line staff from exercising responsibility. Changing this culture will be important for staff and consistent with their assuming the role of advocates for patients.

C. BCMHS BOARD OF TRUSTEES AS ADVOCATES

In October 1992, the Government appointed a new Board for the British Columbia Mental Health Society, composed of community representatives. One-third of the Board's members fell within the definition of "consumers" used in the Mental Health Initiative (i.e., present or former clients of mental health services, or families of same). One objective of changing the Board membership was to inject a form of advocacy into decisions made at Riverview Hospital. Trustees therefore are an important source of informal advocacy. They are in a position to make significant changes in the way the Hospital operates.

While consumers of mental health services now serve on the Board, there are no Trustees who are former patients of the Hospital. We believe that this should be rectified and that consumer representation should include former patients of Riverview. Many trustees of general hospitals have been consumers of the facility's service.

RECOMMENDATION

9-12 That the Ministry of Health appoint at least one former patient of Riverview Hospital as a trustee on the BCMHS Board.

An important role in patient advocacy can be played by staff members and Trustees. Nevertheless, there is an actual, and perceived, conflict of interest between this role and their role as employees or trustees with the Hospital. This is unavoidable. It means that advocacy on behalf of patients cannot end with staff, any more than it can with family members. The dynamics of life on Hospital wards, with the imbalance in power between staff who go home at the end of the day and patients who do not, require there to be external advocacy resources.

D. CONSUMER GROUP ADVOCACY

One of the most encouraging developments relating to mental health issues in British Columbia in recent years has been the increased participation and control of consumers of mental health services through their own advocacy organizations. Consumers, of course, are not necessarily former patients of Riverview or any other hospital facility. For the sake of brevity, however, a reference to "consumers" and "former patients" are used interchangeably in this section.

A number of initiatives in mental health services are intended to recognize and promote the importance of advocacy by consumers and consumer organizations:

- The Ministry of Health appointed a Consumer Advisory Council to advise on the design of mental health services throughout the Province. Members of the Council have undertaken considerable work in order to fulfill this responsibility.

- Consumers are also being appointed to Boards and advisory committees of mental health centres around the Province.

- The World Health Organization's (WHO) chose British Columbia as one of two sites for studying the impact of consumer involvement in the design of mental health services. The British Columbia Division of the Canadian Mental Health Association is coordinating the WHO project, which partly involves the organizing of consumer advocacy around the Province.

Clearly, a great deal is beginning to happen. The physical and financial resources of existing advocacy organizations are, however, often stretched trying to meet these new demands. Nevertheless, in this investigation of Riverview Hospital, it became evident that consumer organizations can and should play an important, positive role. They can support patient advocacy within the Hospital as well as assist and inform patients and the Hospital in their respective transitions.

Like families, former patients have not had a significant voice at Riverview Hospital. Several reasons may explain this. For one thing, periods of illness are difficult, and persons who have left the Hospital are often reluctant to retain a connection with it. Those who are drawn back to engage in advocacy likely do so because of a negative experience as a patient. Their reaction to that experience may not make them welcome at the Hospital.

Precisely because of their critical stance, however, consumer advocates have a great deal to offer present patients and Riverview Hospital alike. They offer independence of views; insights into survival both within and outside the Hospital; and constructive feedback into the patient experience of Hospital life, and how that experience can be improved.

One interesting example of the role former patients can play at a psychiatric hospital is in North Bay, Ontario. There a group of former patients founded People for Equal Partnership in Mental Health ("PEP"), after discovering a common experience of disorientation on being discharged from hospital. They put together a kit of materials containing information on community services, agencies, and supports, and sought to get access to patients before they left hospital. We quote from PEP's submission to the Ombudsman investigation:

> *"The most important aspect of the kit is the initial contact and connection made with the patient in the hospital prior to discharge....We are not talking about a simple introduction to another consumer, we are talking about establishing relationships that will encourage consumers to seek us out. We are trying to change the isolation that people live in.... Consumers do not have a lot of energy, and frequently they don't have the skills, to search through the community to find friends with common experiences who will support them."*

PEP states that the major obstacle it encountered was staff attitude; just getting into wards to meet patients required months of working with senior nursing staff. Getting staff support and encouragement has been more difficult:

> *"What the staff fail to recognize and/or acknowledge is that they have an enormous amount of power and influence over patients, partly because of the patient-staff relationship and partly because of the state of mind that patients are in while hospitalized. When staff make a half-hearted effort to connect us with patients they end up giving a very clear negative message. When they actively send out negative messages they cut their patients off from a valuable supportive connection in the community." (PEP's submission)*

Even Hospital visiting hours policy can support or inhibit consumer advocacy efforts. At Riverview, visiting hours are 1:30 to 4:00 p.m. and 6:00 to 8:30 p.m. for the Adult Division, 11:00 a.m. to 8:00 p.m. in the Geriatric Program. Policy states that "visiting may be restricted for therapeutic reasons." In addition, visitors are required to identify the patient to be visited. One consumer advocate felt that this latter rule discourages advocacy, because it rules out generalized ward visits to speak to unknown individuals or group of patients, or anyone who wishes to come forward to listen or to speak. Recognition that valuable contact can go on with advocates outside of visiting hours is important.

Riverview Hospital should actively encourage the involvement of former patients and advocacy organizations in the life of the Hospital and the patients. This is particularly true during downsizing. In order to avoid the kind of distrust that can undermine such an effort, we recommend several positive steps be taken. These recommendations also require the willingness and capacity of community-based consumers and consumer organizations to become more actively involved in advocacy at Riverview Hospital.

RECOMMENDATIONS

9-13 That Riverview Hospital develop a protocol to permit representatives of designated consumer organizations general access to wards during visiting hours and other pre-arranged times.

9-14 That individuals or advocacy groups denied access to patients be advised of their ability to file a complaint to have the matter reviewed to the internal complaints process.

9-15 That Riverview Hospital take steps to encourage wards and other programs in the Hospital to invite representatives of consumer advocacy groups from the community to speak at gatherings of patients, and that the Hospital monitor the frequency with which this happens.

9-16 That Riverview Hospital develop opportunities to bring consumer advocates from the community together with Hospital administrators and staff, including inviting advocates to sit on Hospital policy and planning committees, and by having staff and advocates work jointly on patient information programs, such as discussions on living successfully in the community with soon-to-be-discharged patients.

9-17 That the Riverview Hospital policy include contacts between patients and consumer advocacy organizations as a part of patients' discharge planning.

3. FORMAL ADVOCACY

A. SUBSTITUTE DECISION-MAKERS AND ADVOCACY

We discussed the legal basis for substitute decision-making where an adult is considered incapable in Chapter Four: Legal Rights. A person appointed as a substitute decision-maker, whether the Public Trustee or a private individual, steps into the shoes of the person deemed incapable for the purposes of certain types of decisions. Are they assuming an advocacy role for that person?

The short answer, in our view, is that "no" the person is not obliged to be an advocate. Advocacy and substitute decision making are different activities. The law gives the substitute decision-maker formal recognition to act in the adult's stead. The substitute decision-maker is not viewed, however, as necessarily being an instructed advocate of the adult; after all, if the adult was capable of giving competent instructions, there would be no basis for appointing a substitute. This poses a question. On what basis does the substitute decision-maker act?

The new guardianship legislation gives direction on this issue. Section 29 of the ***Adult Guardianship Act***, for example sets out the following scheme:

- The substitute decision-maker first must consult with the adult to determine his or her current wishes, and comply with those wishes if it is "in the adult's best interests to do so."

- If current wishes cannot be determined or they are not in the adult's therapeutic interests, the decision-maker must comply with "any instructions or wishes the adult expressed while he or she was capable.

- If pre-expressed instructions or wishes are unknown, the decision-maker must act on the basis of the adult's "known beliefs and values."

- If "beliefs and values" are not known, the decision-maker must act "in the adult's best interests."

However, the decision-maker can apply to court to be exempted from acting on the basis of pre-expressed instructions on the grounds these are not in the person's best interests.

The ***Health Care (Consent) and Care Facility (Admission) Act*** creates a different scheme for substituted consent to health care. Section 19 requires the substitute decision-maker to comply with the adult's pre-expressed instructions when capable; if those are not known, to act on the basis of known beliefs and values; if beliefs and values are not known, in the adult's best interests, taking into account several specified factors. This creates something closer to instructed advocacy -- so long as the instructions were given during a period of capability.

We have reviewed these provisions not simply to show the duties of formal substitute decision-making under the new legislation. These considerations -- known instructions or wishes, beliefs and values, best interests -- may also apply to informal advocates. The difference between advocacy based on instructions or wishes, and advocacy based on best interests is the difference between "This is what J. D. wants, and these are the reasons she should receive it", and "This is what would be best for J. D., and why she should receive it." It is apparent that the two approaches can be in conflict. Where a "best interests" approach is used, the advocate is substituting her or his judgment of what is best for the individual for the individual's own judgment.

The legislation implies that "best interests" is to be the last resort of substitute decision-makers only after looking at considerations more closely identified with the adult's personal wishes. If those wishes or values are not known, then "best interests" is deemed the appropriate basis for decisions. An advocate, strictly speaking, is someone who helps to present the "client's" wishes, or instructions, in as strong a fashion as possible. Without instructions, formal advocacy arguably cannot take place.

We do not think informal advocates have to be looked at with the same rigour. Some informal advocates act on instructions, putting forward the individual's wishes; others see themselves acting not on expressed wishes, but in the individual's best interests (the two things are not, of course, mutually exclusive). Family advocates likely do more the latter than the former. Our point is that it is important to recognize the distinction. This can help in understanding the conflict of interest that informal advocates sometimes face. It also demonstrates the lengths advocates should go to inform themselves about the person's wishes, however difficult that may be.

For many family members, being appointed guardian or substitute decision-maker for a relative at Riverview Hospital may seem attractive as a way to enhance their involvement. A substitute decision-maker may be able to gain access to patient information unless the patient instructs or has instructed otherwise. They may receive greater respect and status from

hospital administration. Legal costs have been a barrier to family members' seeking guardianship orders in the past. It remains unclear at this stage if the process will involve less financial costs to the family under the new legislation.

RECOMMENDATION

9-18 That the Office of the Public Trustee, the Ministry of Health, and Riverview Hospital ensure the preparation of plain language information kits for the use of persons who may wish to consider applying for substitute decision-maker status with respect to a hospitalized patient under the new guardianship legislation. Contained in the package should be information on how individuals can act as advocates for patients as an alternative to seeking appointment as a substitute decision-maker or guardian.

B. LEGAL ADVOCACY

Legal advocacy is a form of instruction-based, formal advocacy. A lawyer's ethical obligations include acting only on instructions from the client, and maintaining all matters in confidence disclosed by the client. A lawyer will certainly advise the client of his or her legal interests; but without instructions, or instructions with which the lawyer believes she or he can ethically comply, legal advocacy will not occur. It follows that only persons capable of giving instructions qualify for legal representation.

Where a person's legal rights are at stake, especially the right to liberty, fairness requires that the person have access to skilled representation before any court or tribunal that has the power to abridge those rights. This principle has been recognized in the design of B.C.'s legal aid system, which seeks to ensure that a lawyer's services are available to individuals who cannot otherwise afford them wherever they are subject to *"criminal proceedings that could lead to ... imprisonment [or] may be imprisoned or confined through civil proceedings."*[26] The B.C. Court of Appeal decided that this means legal service must be made available to individuals involuntarily confined under the ***Mental Health Act***.[27] This judgment has important implications for section 27 applications.

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26 Legal Services Society Act, RSBC 1979, c. 227, 2. 3(2)

27 Gonzales- Dave v. Legal Services Society of B.C. and Attorney General of B.C. (1991) 55 BCLR (2d) 237 (B.C.C.A.)

■ Mental Health Law Program

The Legal Services Society of British Columbia, charged with administering legal aid in the Province, met this requirement by funding a specialized legal clinic for patients. The result is the Mental Health Law Program ("MHLP"), a law office housed in a cottage on the grounds of Riverview Hospital, and operated by Community Legal Assistance Society ("CLAS"). CLAS is a non-profit society providing free legal service to low income and socially disadvantaged individuals across the Province. MHLP is presently staffed with three lawyers, and four paralegals. Representation at Review Panel hearings is provided by paralegals under supervision of the lawyers, who, in addition take on test case litigation and other court proceedings.

MHLP serves an important function in the overall scheme of advocacy for Riverview Hospital patients. As legal advocates, the MHLP Legal Counsel owe to their clients who are patients the same duties of confidentiality as any lawyer owes to her or his client. If anything, these duties are both more important and more onerous in the setting of a mental health facility than in the outside world.

Not all patients who want to challenge their involuntary confinement choose to have a legal advocate. Some patients who may wish to have a legal advocate choose to proceed without legal representation in order to avoid delays in scheduling. This would be a serious concern if delays were common or extended. At present this is not the case but caution about the impact of delays.

By opting to provide legal aid to psychiatric patients through a clinic model, the Legal Services Society declined to put Review Panel representation on a tariff for members of the private bar. In this way, patients do not have a choice of lawyer, unless they are able to pay for the services of a lawyer from their own or available funds. Making our communities inclusive means ensuring generic agencies serve everyone and people needing legal services have choices. A tariff for the private bar would in theory provide opportunities for improved choice for patients. The reality is, at this time, that the dedicated counsel model such as MHLP actually provides greater expertise, understanding and tolerance.

MHLP is meeting the Review Panel needs of Riverview patients, and to some degree, the needs of patients in other Lower Mainland hospitals. The situation outside the Lower Mainland is less clear. Putting Review Panel hearings on a tariff would make representation by private bar lawyers more generally available to patients across British Columbia. MHLP would require more resources to adequately serve the whole province. We are aware that this issue is bound up with a current debate about how legal aid services should be provided in all subject areas -- through funded clinics or by the private bar on tariff. We do not intend to enter that debate here. Whatever its outcome, we believe that serious consideration should be given to providing equitable service to patients regardless of where they receive the services or region in which they want to live.

Expanding the scope of legal representation might also make it easier for patients to bring section 27 applications before the British Columbia Supreme Court, which currently is a statutory right without effective means to access it.

RECOMMENDATION

9-19 That the Attorney General in consultation with the Legal Services Society consider ways of expanding the availability of legal advocacy to patients, particularly those hospitalized outside the Lower Mainland, including representation before the Review Panel or on section 27 Court applications.

4. PATIENT COLLECTIVE SELF-ADVOCACY

Having looked at the informal and formal legal advocacy available to patients at Riverview Hospital, we turn now to patients collective action as self-advocates. In this section, we are concerned with how patients can engage in advocacy on issues of collective interest. First, we examine the place of ward meetings and how these can be made more effective. Second, we review the history of the Patient Empowerment Society at Riverview.

A. WARD (COMMUNITY) MEETINGS

"There were half hour ward meetings each week. I remember that these were dominated by one patient who raised hell all the time and made things difficult."
A Riverview patient

Of 20 wards in Acute Assessment and Treatment, Continuing Treatment and Community Psychiatry, 16 reported holding weekly ward meetings, and one ward each reported meetings on a twice weekly, bi-weekly, monthly, and as permitted by acuteness of illness basis. Five wards described the meetings as "patient-run", ten as "staff-run", and the rest as a mix of the two (e.g., "chaired by a patient, facilitated by staff"). Staff attended all meetings. Most of the wards reported keeping minutes.

We reviewed in detail the procedures of several ward meetings in different Hospital programs. The main purposes of the meetings appeared to be the making of announcements by staff about upcoming activities or program changes, and getting patient volunteers for chores on the ward. Patients were asked to express preferences and vote on group leisure activities such as weekend outings and videos.

"When patients have actual power, things can change. Some ward meetings simply provided nurses with an opportunity to give information to patients. Other ward meetings allow patients to make decisions about ward activities and programs. Many more issues could be turned over to the patients for decision-making at the ward meetings, but we do not believe this could be legislated by policy. It depends very much on the staff and patients involved."
A Riverview staff member

At each meeting, there was time on the agenda for complaints or concerns. Very little was raised or discussed. It was generally true that staff had difficulty getting patients to participate in the meetings. On the other hand, the call for "complaints or concerns" was often made in a somewhat brusque fashion. In one meeting, the staff chairperson said, "Anyone have any complaints?" Hearing nothing, the chairperson quickly moved on to the next item. At another, complaints were left to the end of the meeting; when two patients said they wanted more vocational opportunities, the staff facilitator said it was not a ward matter and there was not enough time to discuss it.

No doubt, the quality of ward meetings varies from ward to ward, and even from week to week, depending on the staff on duty, patients' attending and their ability to participate. It may be difficult to engender discussion some of the time. The conclusion is that continuing efforts need to be made to emphasize and encourage patient participation.

One social worker reported that most ward meetings lacked vitality but that need not be the case. He recalled one ward that had once had animated meetings. Patients were active and vocal participants. He attributed this to the approach taken by the ward physician, who left several issues related to running of the ward to be decided by patients at each of their meetings. The social worker believed patients should make more decisions, or at least express more opinions regarding ward issues. He felt this could even include discussing other patients' privileges or lack of them.

We agree. One of the greatest motivations for participation is believing that you are being listened to, that you can make a difference and that you can influence things you care about. We will not specify issues that could be delegated to patients at ward meetings but believe this should be studied in consultation with patients. Creative efforts to make the meetings a more central part of patient self-advocacy at Riverview should be encouraged. The tradition of non-participation is a challenging one to overcome. Organizing ward community meetings using participatory techniques can go a long way to ensuring patients as individuals and as a group are listened to.

RECOMMENDATIONS

9-20 That Riverview Hospital adopt policy establishing minimum requirements for ward community meetings, including:

- a minimum frequency;
- wherever possible, meetings to be chaired by a patient or when no one is available, or co-chaired by a PES representative;
- minutes of meetings to be typed, kept posted on the ward, and copies forwarded to Directors of Nursing for each Program, the Patient Empowerment Society and the Patient Relations Coordinator;
- meetings to begin by reviewing previous meeting's minutes; and,
- a regular agenda item for issues or complaints of patients, and for updates on responses to issues and action taken raised at earlier meetings.

9-21 That Riverview Hospital and the Patient Empowerment Society undertake a process to identify the kinds of issues that could be delegated for decision by patients at ward meetings.

9-22 That Riverview Hospital provide education and instruction for staff and patients on constructive meeting formats to encourage and maximize participation and consider development of an instruction manual to that end.

B. PATIENT SELF-GOVERNMENT: THE PATIENT EMPOWERMENT SOCIETY AT RIVERVIEW HOSPITAL

This investigation came about in large part because of difficulties that arose between then Patient Concerns Committee and the administration of Riverview Hospital in the summer of 1992. Almost a year later, in May 1993, tensions again escalated to a point where Hospital administration temporarily suspended the activities of the Committee.

The history of this relationship remains to this day a subject of considerable dispute. Versions of what occurred and of the underlying motivations differ in the minds of participants. While this period is important, especially for the patients whose self-directed advocacy group was forged during the events of the past three years, we have limited our review of the details. We wish to highlight only those matters that have particular relevance from the Ombudsman's perspective and matters that help identify the problems that need to be solved if patient collective advocacy at Riverview Hospital is to have a good foundation.

■ Brief History of the Patient Empowerment Society[28] at Riverview Hospital

In 1990 the Hospital was asked to encourage development of the PCC by its eventual chair, then an in-patient. The Riverview Hospital Management Committee approved terms of reference for a "Riverview Hospital Patient Council" in February 1991. The Council was described as a standing committee of the Hospital, reporting to the Board Quality Assurance Committee. The Council's members were to be patients and former patients, indefinite in number, but including "ward delegates", as outlined in the Hospital's 1991 Annual Report. The Council was to be chaired by a patient elected by the members on a rotating six-month basis. Two Hospital staff members were named by management as part-time facilitators for the Council.

28 In this section on history, we refer to the "Patient Concerns Committee", the name used through most of the 1991-1993 period.

The Council, renamed the Patient Concerns Committee (PCC) by the members, held its first meeting in March 1991. It pursued a number of significant issues over the course of the next 18 months, including:

- having the recreation centre at Pennington Hall stay open on weekends and holidays;
- increasing patient access to ward kitchens, including early morning access to make hot drinks;
- several food quality issues;
- free local and long distance telephone service for patients;
- patient input into library purchasing;
- reduction in the price of tobacco and other amenities charged on the grounds;
- increased counselling to help stop smoking;
- input to the Hospital's Charter of Patient Rights;
- efforts to increase the comforts allowance;
- patient control of ward television viewing and newspapers; and
- patient representation on hospital committees and task forces.

Many of these issues appeared to be receiving little or no attention from other parts of the Hospital's operations. Response to the PCCs issues from Hospital staff and administration varied. Some were dealt with quickly, while others lagged. Confusion about channels of communication posed a serious problem.

Management appears to have intended that the PCC would communicate through the staff facilitators. The Committee rejected this idea, and sought to communicate directly with Department Heads, senior management and the Board of Trustees. In early 1992, the Hospital agreed to contract with an outside consultant, first as a co-facilitator with a staff member, and ultimately as sole facilitator for the Society. The question of how to channel communications persisted as a problem.

A second problem developed around a perceived conflict between treatment and advocacy. Decisions by a treatment team to withdraw a patient's privileges or place the patient in seclusion can obviously interfere with his or her opportunities to participate in advocacy activities. In the Spring of 1992, the PCC Chairperson repeatedly had his privileges withdrawn. Although the Hospital announced a policy that patients restricted to their wards would be escorted to PCC meetings, this did not always happen. The first "crisis" involving the PCC culminated in July 1992 when the Chairperson was discharged from Riverview Hospital under disputed circumstances.

The problem with communication channels was closely related to an ongoing issue over the appropriate degree of independence for the Committee. Management had, of course, structured the Society as an internal Hospital committee. The PCC, for its part, sought to achieve increasing autonomy from the Hospital's direction. It passed its own Statement of Purpose, and later a Constitution, accompanied by discussion of turning the Committee into a registered society.

At the same time as the PCC sought greater autonomy, however, it also increased its demands on the Hospital for resources and responsiveness to its needs as a working Committee. Administration staff spent long hours receiving requests from the PCC. The resistance by management to respond to the demands resulted in considerable tension. This diverted the attention away from the substantive issues raised by the PCC related to patient environment. Indeed, progress on a number of the substantive issues was being made at the same time as tension over process questions increased. The latter led to the second "crisis" in relations between the Hospital and the PCC.

During the Spring of 1993, the former Chairperson had become Acting Chair, and was seeking readmission to Riverview Hospital as a patient. Hospital administration, finding demands on its time and resources growing, sought to restrict his involvement. It argued that a former patient could not serve as Chairperson. As the annual PCC elections scheduled for May 28, 1993 approached, these issues still had not been resolved. On May 26, 1993 the Hospital announced that it was temporarily suspending the Society.

The decision to suspend the PCC was unfortunate. Despite the operational and communications difficulties cited above, the Hospital had been dealing with the PCC as it then existed. Suspending the Committee two days before its scheduled elections showed poor judgment.

Since that time and since regular meetings have been set, relations between the PCC and Riverview Hospital have improved considerably. The Board of Trustees of BCMHS recognized the Committee and its executive in mid-summer, and the Hospital arranged for the PCC to use a cottage on the grounds for an office. The Board of Trustees continues to provide funding to the PCC budget, to be administered through an external advocacy group, the B.C. Coalition of People with Disabilities. These and other positive developments are a credit to both parties.

The PCC changed its name briefly to the Patients Concerns Society. This was the first step in the move from a Committee of the Hospital to an independent society. Their intention to change their status was finalized by the recent incorporation of the A.D. Patient Empowerment Society.

We wish now to review the problems reflected in the events described, many of which seem inherent to collective advocacy by patients in psychiatric hospitals.

■ Problem Areas

Conflict Between Advocacy and Treatment

There is the potential for a conflict between advocacy and treatment in an institutionalized setting. In the past, when advocacy by and for patients was not considered, this was not a problem. More recently, with advocacy on many fronts gaining prominence and attention, hospitals have been challenged to respond. The principal focus of any hospital is treatment and care of its patients. Treatment includes administration of medications which, in the case of psychiatric illness, can have serious consequences and side-effects. Through the use of medication and certification, physicians and nurses exercise considerable control of patient's behaviour and environment. Some patients perceive that treatment, on occasion, will be used to disengage them from advocacy work. Some people working within the Hospital may find advocacy efforts threatening and confrontational. This perception on the part of patients and this attitude on the part of staff deserve serious attention.

Many of the recommendations in this report will assist patients to guard against this possibility. If a treatment decision is viewed as coercive, a second opinion can be sought. If a restriction on activity is justified on a therapeutic basis, the individual can complain and seek a review. Where patients are not in a position to complain, the Hospital administration must be on the alert to ensure that treatment by staff is not used as a reason to stop people from engaging in advocacy activities. Some people encourage advocacy on the basis that it is "therapeutic." This is dangerous and inconsistent. Advocacy may contribute to an individual's mental health and improve social skills. These may be positive outcomes of advocacy work but are not the objectives of it. Measuring the importance of advocacy on standards not employed elsewhere in the community is unhelpful. People who are ill are entitled to advocate on behalf of themselves and others.

- **Autonomy of Patient Empowerment Society/Conflict for the Hospital**

There was considerable tension between the Hospital's administration and the PCC. The Committee challenged the Hospital with its demands. The Hospital did not always respond appropriately and did not view the PCC's efforts as healthy agitation. For advocacy by a patient collective to be truly effective, it requires resources. The Hospital agreed to provide some financial support to the PCC while it was a committee and has been forthcoming with additional financial support to the PES more recently.

There will always be the potential for conflict in an arrangement whereby the patient collective advocacy group is dependent on the very facility against which it is agitating. This arrangement is unfair for both parties. PES should be able to achieve as much autonomy as possible to be free to speak out without fear of reprisal. The Hospital must not be placed in the untenable position of making a resource allocation decision that may in fact have been made for legitimate financial reasons but which has the appearance of being a decision intended to prejudice the efforts of the PES.

It is incumbent for the Hospital to welcome advocacy by the PES or whatever patient collective advocacy groups evolve in the future There must be demonstrated support, in principle, for adequate resources for the PES demonstrated by the Hospital. Funding, however, should be insulated from Hospital control.

- **Representation Issues**

Problems have and continue to arise relating to how the PES can represent the views of Riverview patients, whether it has done so, and whether Riverview Hospital has recognized it as a representative entity.

Before looking at a few specific issues, it may be worthwhile to consider difficulties in this area inherent to the psychiatric hospital setting. The patient population is transient, with a large number of admissions and discharges each month. Many patients have acute symptoms of illness or treatment, or serious impairment of daily living skills and judgment. A patient may not be fully able to deal with the standard activities of an advocacy committee or organization -- regular attendance, reviewing minutes of previous meetings, the Rules of Order, following through on work commitments, etc. Information we received about patient councils in psychiatric hospitals in other provinces suggested that problems with representation and continuity were common.

"The rapid turnover in patients, as well as the illness experienced by the patients seemed to make it impossible for the Patient Empowerment Society to establish continuity in its activities."
A Ministry of Health official

Representation to a patient council from each Hospital ward, which might seem an appropriate basis for membership and voting rights, can be encouraged but is not necessarily a model guaranteed to succeed. Certain wards may be incapable of selecting a delegate; delegates might not attend committee meetings, on a regular basis or at all; and patients not selected as delegates might well wish to attend and have their opinions heard. Other representational schemes have similar drawbacks. It seems inescapable and perhaps appropriate that membership and attendance at meetings have to remain open and relatively unorganized.

In this environment, patient councils owe much of their success or failure to the particular individuals who take an active interest in their activities at any one time. An individual with a strong personality and organizational skills can have as great an influence as would be the case in the community at large.

"I relly like the idea of the Patients' Concerns Committee, but the bottom line is it's never going to happen because professionals in the hospital make sure it doesn't..... It's another way of making the hospital look good to the outside -- to the advocates and organizations that lobby for change."
A Riverview patient

There are risks in this kind of organizational environment. First, the representative basis of PES positions can be questioned. Second, the long-term success of the PES is put in doubt. That success is measured by whether the PES can establish itself as an ongoing voice for the collective interests of patients under changing leadership.

This need for continuity emphasizes the desirability of having former patients and consumer organizations play active roles in the PES. They have a great deal to offer, including continuity, and knowledge of how advocacy groups function. They may be able to assist in developing training programs to help patients acquire skills needed for developing strategies and developing the business of a functioning advocacy committee including meetings and elections.

We do not think former patients should, as a matter of principle, be prevented from voting or holding elected executive positions within the PES, so long as in-patients remain a majority.

■ Administration's Attitude toward the PES

Riverview brought forward the proposal for a Patient Council because of criticism in the 1989 Accreditation Report. Management may genuinely have wanted a body that would improve communication between itself and patients, but it seemed unprepared to deal with advocacy that had an adversarial flavor. Advocacy will, if effective, always have some of that flavor, although the degree may vary widely. In many ways, it appears that management was not ready for, or welcoming of, advocacy by

patients. We think this explains, in part, why administrators of this major mental health facility overreacted to particular situations.

■ Framework for a Patient Advocacy Body at Riverview Hospital

The legitimacy of having a patient-run advocacy body at a psychiatric hospital is evident, and we believe this has been formally recognized by Riverview Hospital. The Patient Empowerment Society proved valuable in many instances when bringing forward issues that had not received enough attention by Hospital administration.

The future viability of such a patient body at Riverview Hospital depends on overcoming the problems that plagued the PES's relationship with Riverview Hospital. Crucial to this is the willingness of Hospital administrators and staff to see patient collective advocacy as necessary to their success as a fair and just psychiatric hospital.

We do not intend to give detailed proposals for the structure and design of patient advocacy. These are fluid issues that need to be worked out by the parties involved, not least by present and former Riverview Hospital patients. It would be inconsistent with basic principles to dictate the specifics of a self-advocacy organization. Also, the jurisdiction of the Ombudsman extends only to Provincial government authorities. Our recommendations are directed primarily to those authorities with respect to how they recognize and respond to advocacy as a matter of fairness.

In the following, we refer to a "patient advocacy body" or "group", rather than to the Patient Empowerment Society specifically. We do this because our comments are prospective, and deal with general principles that support patient collective advocacy. They should apply to other psychiatric hospitals in B.C. as well as Riverview. PES has worked to establish itself at Riverview, and will in all likelihood continue in this role. Much of what follows has already been put in place by the PES.

□ Mandate

The mandate of the patient advocacy body should extend to raising issues of collective interest to patients as a whole, or to groups of patients. In other words, this body should deal with systemic issues. It is likely the case that most such issues would deal with what we termed "quality of life" matters. Policy issues in the areas of treatment and discharge might also be addressed. The patient body could serve as a voice for Hospital patients on wider mental health issues, including availability of community services, and legislative reform. We believe

voice for Hospital patients on wider mental health issues, including availability of community services, and legislative reform. We believe the mandate of the advocacy body should not extend to individual patient complaints, because of difficult questions related to confidentiality and conflict of interest these could raise. This would not preclude the group from acting on a systemic issue raised by a particular individual complaint. The advocacy body, in addition, could within this mandate, support individual patients to access mechanisms to have their concerns addressed.

- **Autonomy and Terms of Reference**

A patient advocacy body at Riverview Hospital should now be established on the basis of independence from the internal decision-making structure of the Hospital. Advocacy in its true sense requires independence. PES has clearly evolved to a point where this is possible.

The most important issues in this regard relate to funding, resources and terms of reference. The patient advocacy body should operate with its own budget, approved and funded by the Mental Health Services Division of the Ministry of Health. This Division is already engaged in funding the development of consumer and family advocacy in mental health services, and it is appropriate that it undertake the same with respect to consumers at Riverview Hospital. It may be, as we discuss in Chapter Ten, that funding for mental health advocacy should become the responsibility of another branch of government more removed from direct service delivery. This will depend on the extent to which the Ministry remains responsible for any direct service delivery after the re-organization of health is complete. For the time being, however, consumer advocacy at Riverview Hospital ought to be brought under the same funding arrangements that cover advocacy in the community.

We believe this to be a necessary step in order to create a separation between the advocacy body and Hospital administration regarding resource issues that have caused friction in the past. The patient body should assume responsibility for purchasing clerical support, equipment and supplies. Riverview Hospital should cooperate where possible with the advocacy body for the sake of efficiency, and to support its activity. For example, the body should be enabled to purchase supplies and services from the Hospital at prevailing costs, and to arrange to buy materials through Hospital purchasing. Further, the Hospital should continue to make appropriate office space available on the grounds, as it did through the Fall of 1993 and is at the time of writing.

In the longer term, a more creative approach to funding patient advocacy may be appropriate. In Chapter Ten we discuss in greater detail the Provincial Government's role and responsibility toward funding advocacy services in mental health. It may be that a different Ministry, branch or agency of the Government, should assume this function. The goal would be to ensure that advocacy is supported, while separating that financial support from the parts of Government which exercise decision-making authority over mental health services. One approach worth studying would be for advocacy funding to be provided through a recognized non-profit public interest agency that could undertake the monitoring of advocacy independently of the Government as the original source of funding.

If the patient advocacy body is to operate on its own funding, the question arises of whether it should be legally constituted as a society. That is a question for members of the advocacy group to decide. When public funds are provided to a non-governmental organization, the funding agency appropriately looks for forms of accountability, and one of those is usually that the organization has legal status. This may not always be required, and we hope the Ministry of Health will show flexibility in this area. This is not a problem for PES as it has incorporated as a society.

An interim solution to this question might involve the funds being administered through an existing non-profit society, much as the B.C. Coalition of People with Disabilities did with the Patient Empowerment Society. The established society could assist the patient body with financial administration, including a process for cheque authorization, eventually assisting it to become incorporated. This is a model of transition that may be helpful to other hospitals.

We had concerns about two possible drawbacks to constituting the advocacy body as a society. The first was whether this would so underline the separation of that body from Riverview Hospital as to relieve the Hospital of any responsibility to work with it. We believe, however, that responsibility is rooted in administrative fairness to which the patients are entitled and exists regardless of the legal status of the advocacy group. Below, we address the kind of protocols that should be developed to meet that responsibility.

Second, we were concerned that complying with the requirements of the ***Society Act*** might introduce a formality that may, from time to time, be unrealistic in the psychiatric hospital setting. In the end, we do

members and directors, including voting rights, could assist in developing routine democratic process for the advocacy body. If the advocacy body is properly supported, these legal requirements ought not to be a barrier.

☐ Protocols and Reporting Relationship With Riverview Hospital

When the patient advocacy body is fully independent of Riverview Hospital, the Hospital does not have obligations to it in the same way as if that body was an internal committee. That is the consequence of taking the advocacy group outside the Hospital's decision-making structure. Riverview Hospital and the patient advocacy group must delineate responsibilities and be established as separate entities.

This Report is about administrative fairness -- Riverview Hospital's fairness and openness to hearing the concerns of its client groups, including the development of a responsive and pro-active internal complaints handling process. We believe that an important part of administrative fairness in this context is being open and working with advocates for those clients. That, in short, is the theme of this Chapter.

Nowhere is the Hospital's willingness to work with advocates more necessary, or more tested, than when it comes to patient collective advocacy. We outlined several problems that appear endemic to this type of advocacy in psychiatric hospitals. These problems pose understandable difficulties for staff and administrators, even those most inclined to support advocacy efforts. For that very reason, we believe a fair measure of a hospital's commitment to openness is the degree to which it goes out of its way to encourage and cooperate with a patient advocacy body. We did not find that Riverview Hospital measured up well on this scale in the earlier events we reviewed. However, there are clear signs this is changing -- we point in particular to the Hospital's initiation of and participation in the Advocacy Project Team's work.

Therefore, even where the patient advocacy group is autonomous, we believe Riverview Hospital has an obligation in administrative fairness to develop protocols with the group that facilitate open exchanges of information and responsiveness to concerns it raises. The details of those protocols need to be determined by the parties, likely on an ongoing basis. We have a few general suggestions.

- **Point of Contact**

  A point of contact should be established between the advocacy group and the Hospital at a senior management level. This could involve a management team that met regularly with the executive committee of the group. The meetings should be opportunities for concerns to be brought to management, and for management to report on actions taken with respect to them, as well as for discussing ways to expand and require cooperation. In order to track issues and responses in a way that is easily manageable for all concerned, minutes ought to be taken and available.

- **Flexibility**

  Establishing this point of contact should not preclude lower level contacts between the advocacy group and Hospital staff, which can contribute to the resolution of minor issues and the general acceptance of advocacy at Riverview. However, fairness is a two-way street. In order that the Hospital be enabled to give effective responses, it needs the chance to coordinate them. It is reasonable that any issue of substance be raised through one focal point. We mentioned that a problem in the relationship between the PES and the Hospital had been "communications overload." We would hope that by having a protocol that formalizes channels for communication, while still leaving room for flexibility, this problem can be avoided in the future.

- **Board Commitment**

  In addition to regular meetings with senior management, we believe the Board of Trustees of BCMHS should afford time at its meetings, perhaps on a quarterly basis, to hear from the patient advocacy body. This would allow the advocates to raise unresolved issues with the Hospital's governing authority, and permit the Board a first-hand opportunity to see how advocacy efforts are being received at the Hospital. These meetings should permit ample time for patients to express their views and concerns. The quarterly meeting would not preclude the Board from having other less formal "get-togethers" to get to know the group. The advocacy group, like any independent organization, would always have access to external channels, including the Ombudsman, elected officials and the news media.

The advocacy relationship is by its nature an uneasy one. It is particularly uneasy when the advocate belongs to a group that has historically been marginalized and discredited. Institutions are challenged by good advocates. Those challenges can be awkward, and sometimes painful. A psychiatric hospital like Riverview must rise above the awkwardness if it is to meet a standard of fairness to patients. At the same time, good advocacy depends on the advocates' achieving a degree of credibility with the institution and the interested public -- credibility that comes from the ability to show respect, as well as from demonstrating a strong voice.

☐ Representativeness and Membership

Part of having a strong and effective voice as an advocacy group is being able to demonstrate that it is a representative voice. Riverview Hospital had questioned the representativeness of the PES at crucial times. There are good reasons why it is not appropriate to place too many demands of representativeness on a patient-run advocacy body. We believe that "representation" should be understood to come from the quality of the positions being taken by the body, as well as from the breadth of its active membership.

A lawful society, will, of course, have to comply with statutory requirements governing the rights of members and the duties and powers of directors. That may assist it in maintaining basic rules of democratic practice. Many of these have already been put in place by the PES.

It is not our role to set out strict guidelines for the internal organization of an independent advocacy group. A few general comments are that we think membership with voting rights should be open to any present or former patient of Riverview Hospital. Present patients should be assured of retaining the greater influence in the group. That might be accomplished by adopting rules saying that a majority of the Executive or Board members must be present patients, or stating that a meeting would be deemed to have a quorum only if a majority of voting members at the meeting were present patients. Beyond that, we do not believe that Executive positions should be limited only to present patient members.

Elaborate systems based on delegates from wards or program areas are likely to be recipes for failure. While wards should be encouraged to send patients to the advocacy group's meetings, even as informal delegates elected by fellow patients on the ward, membership and voting rights should not be ward-based or limited by other representational models that cannot be realistically relied on to sustain continuity and can easily be used to discredit the group.

The issue was raised with us whether patients should receive payment for their advocacy activity. In light of the lack of funds which most patients experience, there may be a need to provide compensation for time lost to paid vocational work due to attending regularly scheduled advocacy meetings. Would be participants may be reluctant to attend meetings held during the work day unless they are assured of continuing to receive their stipend. Workers who participate in union work is a good analogy.

- **Advisory Committee**

Many of the issues discussed here are complicated, and will take time to work out. The successful development of a patient advocacy body at Riverview Hospital would be assisted by having an Advisory Committee to that group, at least in its early stages. Given that the group is to be external to the Hospital, the ideal parties to form an Advisory Committee would be representatives of consumer organizations that had the trust and confidence of Riverview Hospital patients. We encourage the Hospital and the Ministry of Health to facilitate the involvement of those organizations in this way.

RECOMMENDATIONS

9-23 That Riverview Hospital adopt policy that recognizes and affirms the legitimate role of a patient advocacy body run by present and former patients, and independent of the Hospital's governing authority, in representing a collective voice of patients and engaging in advocacy on systemic issues of concern to Hospital patients.

9-24 That Riverview Hospital work with a patient-run advocacy body to develop protocols covering such issues as the use of facilities on hospital grounds for office and meeting space, and a flexible, effective and meaningful communication and reporting relationship between the Hospital and that body.

9-25 That Riverview Hospital adopt a policy encouraging staff involved in patient care to be supportive of, and respectful toward the participation of individual patients in collective patient advocacy.

9-26 That Riverview adopt policy stating that all patients who wish to attend regularly scheduled meetings of the patient-run advocacy body have the right to do so, including the right to be escorted if they do not have ground privileges, unless their attendance would constitute a real danger to self or others, which reasons are to be documented by the attending physician.

9-27 That Riverview Hospital adopt policy stating that patients who attend regularly scheduled advocacy meetings be compensated for the time away from their usual vocational work placement.

9-28 That the complaints process and treatment review mechanisms discussed earlier in this report be made available to individual patients who believe treatment decisions are unfairly or unreasonably restricting their patient advocacy activities.

9-29 That pending any decision to coordinate the funding of a range of advocacy activities through other Ministries or branches of the Provincial Government, or through non-profit public interest agencies in the community, the Ministry of Health provide core funding for the activities of the patient advocacy body at Riverview Hospital.

CHAPTER TEN
A PROVINCIAL FRAMEWORK FOR INDIVIDUAL ADVOCACY

1. A GAP IN ADVOCACY SERVICES

Having reviewed in some detail issues surrounding the way in which systemic advocacy by patients as a group can be supported, we turn in this Chapter to address a significant gap in advocacy, both for patients of Riverview Hospital and clients of mental health services in B.C. generally. Our discussion and recommendations draw in part on the work of the Advocacy Project Team at Riverview Hospital.

In the last Chapter, we reviewed the range of existing sources of advocacy that support patients at Riverview Hospital. These include various sources of informal advocacy, and patient collective advocacy, about which we made extensive recommendations directed at more firmly establishing its role. We believe that one important and necessary stream of advocacy is missing from the present scheme:

> ***formal*** *advocacy on behalf of* ***individual*** *patients and family members in* ***non-legal*** *matters -- i.e., quality of life, treatment, and discharge issues.*

Taking each of the underlined words in turn:

- **Formal advocacy**

  A number of informal advocacy services, including family, staff, and former patients, have been identified. As stated, these natural advocates deserve encouragement and support. As informal sources, however, they face certain difficulties, particularly with respect to access to patient records and confidentiality. One of the benefits of a formal source for advocacy, established in legislative or policy guidelines, is that powers and duties of this kind can be established as a right. Formal advocacy can and should empower informal advocates by giving them a place to bring issues for more sustained inquiry and pressure. It should not be seen as supplanting them.

- **Individual advocacy**
  Advocacy on behalf of individuals is different from advocacy on behalf of a group, or systemic advocacy. We have touched on the confidentiality issue, which also arises here. In addition to that, there is a potential conflict of interest between individual and group advocacy. Organizations which do group advocacy do so on the basis of collective interest, usually developed through forms of representative voting or meeting procedures. An organization might decide, for instance, that it will advocate for mixed gender wards throughout Riverview Hospital because its members believe that is the most normalizing living environment for patients.

  Most organizations engaged in group advocacy do not have the time or energy to focus on individual issues which do not relate to their vision for systemic change. We have seen that group advocacy in the mental health field is still in its early years. That is true for former patient groups, family groups, and the Patient Empowerment Society. We believe advocacy of individual interests requires separate attention.

- **Non-legal issues**
  Formal advocacy is presently available with respect to the most important legal right of involuntarily committed patients -- the right to have a hearing before a Review Panel. We have commented briefly on the way in which legal representation is currently provided, including the need for some expansion in those services.

  There is no formal advocacy available with respect to quality of life, treatment, or discharge issues. With respect to discharge issues we note one further gap in advocacy that should also be addressed: advocacy that is available across the continuum of mental health services. In Chapter Seven, we stressed the need to view patients in a dynamic fashion, as people in transition from hospital to community mental health services. The system itself is in transition to a "closer to home" model of service delivery. Nevertheless, advocacy may currently be less available in the community than it is at Riverview Hospital. Any new advocacy services should be designed with the continuum in mind.

  We believe this gap in formal non-legal advocacy for individual patients needs to be met by the Provincial Government. Two Provinces, Alberta and Ontario, have addressed the same question by setting up provincial advocacy offices. We describe these examples in the next section.

2. THE ALBERTA AND ONTARIO MODELS

Alberta established its Mental Health Patient Advocate Office by statute in 1990. Section 45 of the Alberta ***Mental Health Act*** R.S.A. 1988, c. M-13.1, as amended, states that Cabinet:

> *"shall appoint a Mental Health Patient Advocate, who shall investigate complaints from or relating to formal [i.e., involuntary] patients..."*

The ***Act*** empowers the Advocate to employ lawyers or psychiatrists to assist in carrying out particular investigative activities. Regulations passed pursuant to the ***Act*** make it apparent that the Advocate has responsibilities and powers similar to those of the Ombudsman but the advocate is not an independent Officer of the Legislature. Its powers include access to documents, including medical records, access to patients, and the power to make recommendations at the conclusion of an investigation.

The Advocate Office in Alberta is also charged with providing information about rights to involuntary patients, and assisting them in obtaining counsel for Review Panel hearings. It reports that it has assumed a role of promoting public awareness about patients' rights and perspectives in mental health. In its 1993 Annual Report, the Office reported opening 368 complaint files in 1992, raising 926 issues. The Advocate has jurisdiction with respect to 14 public and private psychiatric hospitals and units that admit patients on an involuntary basis. The Advocate only serves institutionalized ***and*** involuntary patients who are mentally ill. The Advocate and two staff investigators advise they make visits to each of these facilities on a regular basis.

Following the Ombudsman model, the Advocate does not act on "instructions" from patients, but rather investigates their complaints in an impartial manner. The patient has a right to make representations to the Advocate, but does not control the investigative process. The Advocate is under a statutory obligation not to disclose information acquired in the course of investigation. The Advocate and the Ombudsman of Alberta often refer complaints to each other, but the Ombudsman does not have jurisdiction over private psychiatric facilities.

In contrast to this investigative statutory model is the advocacy model employed by the Psychiatric Patient Advocacy Office (PPAO) in Ontario.[29] The PPAO, created in 1981, is funded by the Ministry of Health to provide advocacy for involuntary ***and*** voluntary patients in Ontario's ten government-operated psychiatric hospitals. The PPAO has a central office in Toronto, and offices in each of the ten hospitals, staffed by an Advocate and a Rights Advisor. An Advisory Committee appointed by the Minister of Health assists a Provincial Coordinator in identifying priorities and goals for the Office. There is no governing statute.

The mandate of the PPAO was originally restricted to undertaking instructed advocacy for patients in non-legal matters, including treatment. The PPAO then started to develop systemic issues of concern to the broad range of patients, as those emerged from its casework. The question of whether the PPAO should go beyond instructed advocacy to acting without instructions on behalf of patients unable to articulate their wishes, or for patients as a whole, became a matter of debate. It was decided this was necessary if advocacy on systemic issues was to prosper. The mandate of the PPAO has, therefore, been changed to providing instructed, non-instructed and systemic advocacy.

Advocates report annually to the boards of the psychiatric hospitals on the nature of issues raised by patients, problems in advocacy, and related matters. They have also been available to assist groups of former patients and in-patients with their advocacy activities.

The Second Report of the PPAO in 1987, the last one published, reported 3,681 files in a one-year period, which raised 6,513 issues; 21% of the latter were therapeutic in nature, 26% were "social/custodial", and 43% legal (most of which resulted in giving information and making referrals).

As mentioned, the PPAO does not have a statutory foundation. The mandate, duties and responsibilities of advocates are set out in guidelines and protocols developed by the Ministry of Health and with the hospitals. Advocates have access to patient clinical records on the basis of acting on instructions, and owe a duty of confidentiality to clients. In late 1992, the Ontario Legislature passed ***An Act Respecting the Provision of Advocacy Services to Vulnerable Persons***, which sets out a detailed structure for a

[29]The following articles analyzed the purpose and performance of the PPAO in its first few years: Atkinson, Susan & Madill, Mary-Frances. (1985) "Mental health advocacy: paradigm or panacea?" *Canada's Mental Health* 33(3), 3-7; Galbraith, D.A. (1985) "Advocacy for patients: are outsiders necessary? A psychiatric hospital perspective" *Health Law in Canada* 8(4), 108-111; Turner, Tyrone, Madill, Mary-Frances, & Solberg, D. (1984) "Patient advocacy: the Ontario experience." *International Journal of Law and Psychiatry* 7(304), 329-350.

range of advocacy services. It is anticipated that the PPAO will be brought under this statute, formalizing a number of issues including access to records and confidentiality.

As an advocacy model, the PPAO has not had a specific power to recommend or make decisions regarding issues brought to it by patients. Instead, advocates seek to put forward a patient's position to responsible hospital officials, and obtain a resolution satisfactory to the patient. In its early years, the PPAO encountered resistance to its activities at some hospitals, and often operated in an adversarial atmosphere. The degree of acceptance of PPAO advocates has apparently significantly increased since that time.

3. A BRITISH COLUMBIA MODEL

A. CONSIDERATIONS FOR B.C.

Both the Alberta and Ontario advocacy office models have some appeal. One of the main benefits of their work is that they raise public awareness of mental health issues. The Alberta MHPAO reports publicly each year on the range of issues encountered in its advocacy, as well as on the overall fairness of psychiatric hospital programs and services. The PPAO offices in Ontario give annual reports to the boards of their respective hospitals.

Other features of these two models may be less relevant to B.C. As pointed out, the need to be addressed in B.C. is that of individual advocacy. For that reason, the investigative model employed in Alberta may not be appropriate. Investigative powers with respect to mental health services, including hospitals, already rest with the Ombudsman of British Columbia. The new Councils to be set up in communities under "closer to home" are within the Ombudsman's jurisdiction (an Order-in-Council in May 1994 confirmed this jurisdiction).

Another factor that comes into consideration in designing an advocacy model for B.C. is location. The PPAO in Ontario has offices at ten provincial hospital facilities. The situation in B.C. is considerably different, since Riverview Hospital remains the only provincial psychiatric hospital. Even when tertiary care beds are developed in three other regions of B.C., these will be within much smaller facilities than Riverview. To house an advocacy office at Riverview, may detract from its ability to serve non-Riverview patients and clients.

This is an important point because we believe that advocacy should track, as much as possible, the continuum of service that is the goal of mental health services in B.C. For that reason, an advocacy office should not be limited to involuntary patients, as is the case in Alberta; nor should it be limited to hospital in-patients, as is the case in both Alberta and Ontario. We think advocacy service should extend at least as far as issues arising from discharge planning after a patient has left hospital, and issues related to hospital admission. We would prefer to see the advocacy service designed even more broadly, so that it could engage in advocacy with respect to institutional and community mental health services.

There is no question it would be a challenging task to ensure that the advocacy needs of clients located around the Province, residing both in hospitals and in the community, were being met. Advocacy with hospital boards and administrators would be a different task than advocacy directed at Mental Health Centres and service providers. It is here that the work of the Advocacy Project Team (APT) initiated by Riverview Hospital provides guidance.

The APT, of course, was primarily concerned with designing an advocacy system for the Hospital. In its Framework document it proposes a system with two component programs: a Systemic/Group Advocacy Program operated by present and former Hospital patients, and an Individual Advocacy Program. The former corresponds in general terms with the outline of the parameters for patient collective advocacy in Chapter Nine.

The Individual Advocacy Program addresses the gap in services discussed in this Chapter. This Program would have the features of providing individual patient advocacy on a formal basis in non-legal matters. It would be operated through an existing non-profit society with experience in advocacy, with funding from the Provincial Government. As the APT's Report states, this would begin as a program specific to Riverview Hospital:

> *"The scope of this project is limited to Riverview Hospital. It is anticipated that this model has the potential to be implemented for patients and clients of the mental health system across the Province. For this to occur effectively, advocacy should be considered a core health service."*

We find this proposal of considerable interest, not least because it was developed through a consultative process that brought together a number of concerned and knowledgeable parties, including representatives of the Patient Empowerment Society.

By "core health service", the APT refers to the ongoing process of defining certain health services as core services in the planning for a regionally-based health care system in B.C. We agree with the APT in principle, but caution about seeing advocacy as a "health" or treatment issue as we referred to earlier.

The proposal also points to a different way to provide individual advocacy than that chosen in Alberta and Ontario: rather than having front-line advocacy done by staff of a single centralized agency, develop a network of community-based services that can respond to the particular needs of regions, and of client populations (i.e., hospitalized patients, and clients in the community.)

The model we propose seeks to combine elements from these sources. It has two components:

- A Mental Health Advocate, appointed to report to the public on issues in mental health advocacy, and provide an information and referral service, but not to engage in front-line advocacy; and

- A network of community-based programs providing front-line advocacy to consumers of mental health services, including the Individual Advocacy Program at Riverview Hospital.

Before returning to this proposed model, we want to look at the Provincial Government role in supporting the kind of advocacy program proposed by the APT. That role involves both funding, and coordination.

B. THE PROVINCIAL GOVERNMENT ROLE

The primary public responsibility in facilitating the creation of advocacy programs is funding the service. Hand in hand with funding goes a responsibility to establish criteria and standards to be met by programs seeking funding, and monitoring or auditing of programs' performance. Establishing practice and ethics criteria for formal advocacy programs will be especially important with such a new activity.

Without public funding, such programs will not happen. As pointed out in Chapter Nine, the Mental Health Services Division of the Ministry of Health has undertaken funding for consumer and family advocacy. We believe it appropriate that funding be made available both for patient collective advocacy, as already discussed, and a formal individual advocacy

program at Riverview Hospital. If necessary, the latter could serve as a form of "pilot project" for advocacy programs serving other mental health constituencies.

We noted discomfort in the community regarding a perceived conflict of interest if the Government acts as a funder of advocacy, which may often be directed against Provincial authorities. To some extent, this conflict is inherent, and must be approached with expressions of good faith on all sides. There may be creative ways to reduce the perception of conflict. One way is to consider a model whereby funding is provided indirectly through an agency independent of Government that would assume responsibilities for administration and monitoring. We heard praise, for example, for the way in which the Law Foundation of British Columbia has dealt with non-profit societies to whom it has granted funds for legal and lay advocacy programs.

This would be consistent with plans for administering formal advocacy programs in the guardianship field. The new guardianship legislation expressly refers to advocates being available to support vulnerable adults at specified stages of the guardianship process.[30] By using the phrase "prescribed advocacy organizations", the legislation implies a scheme whereby advocacy will be provided by non-profit societies which meet eligibility criteria and receive public funding. Planning for the development of this statutorily mandated scheme is ongoing.

C. A PROPOSED MODEL FOR ADVOCACY

With the foregoing considerations in mind, we turn now to a proposal for bringing about formal advocacy for individual clients of mental health services, both at Riverview Hospital and elsewhere in the Province. It has two parts.

First, there is a need for mental health advocacy to be spearheaded by a figure who can give it a public profile and monitor progress made in developing advocacy services. To that end we recommend the appointment of a Mental Health Advocate for the Province of British Columbia. The Advocate's principal responsibilities would include reporting publicly on advocacy issues, and providing a research, information and referral service to support advocacy services. The Advocate would not engage in front-line advocacy on behalf of individual

[30] For example, section 8(2) of the ***Adult Guardianship Act*** states that a copy of the materials of an application to court for the appointment of a guardian must be served on "a prescribed advocacy organization", which then has standing to attend and make representations before the court. Section 63(b) gives authority to make regulations "prescribing advocacy organizations", but the term is not otherwise defined.

clients. The reporting function could be achieved through reports provided to the Minister of Health, or tabled annually with the Legislature, and released to the public.

RECOMMENDATION

10-1 That the Provincial Government appoint a Mental Health Advocate for the Province of British Columbia, with the following mandate:

- to report annually and as required to the public on the state of the mental health service system in B.C., and on the issues being encountered by consumers, service providers, advocates, and those they support; and
- to provide a single information and referral source for advocacy resources in mental health services in B.C.

That the model be based on a consultation with community organizations and that the Ministry of Health amke a proposal for the model within 2 to 3 months of this Report.

Front-line advocacy service would be provided by advocacy programs, such as that proposed by the Advocacy Project Team for Riverview Hospital. While seeing that as a program that deserves priority attention, we believe it should be an early step in the development of a network of advocacy services that could support individual mental health consumers at future tertiary care sites, and living in the community. It would be unfair to only create an advocacy program at Riverview Hospital that would tend to reinforce a sense of its isolation in mental health services generally. Our last recommendation is directed at encouraging Riverview Hospital to continue the support it has given through the APT to the development of a formal, non-legal advocacy program at the Hospital.

RECOMMENDATIONS

10-2 That in addition to appointing a Mental Health Advocate, the Provincial Government, in consultation with Riverview Hospital and community advocacy organizations, support the creation of a network of advocacy services for individual consumers of mental health services, including a program for non-legal advocacy for individual patients at Riverview Hospital, by:

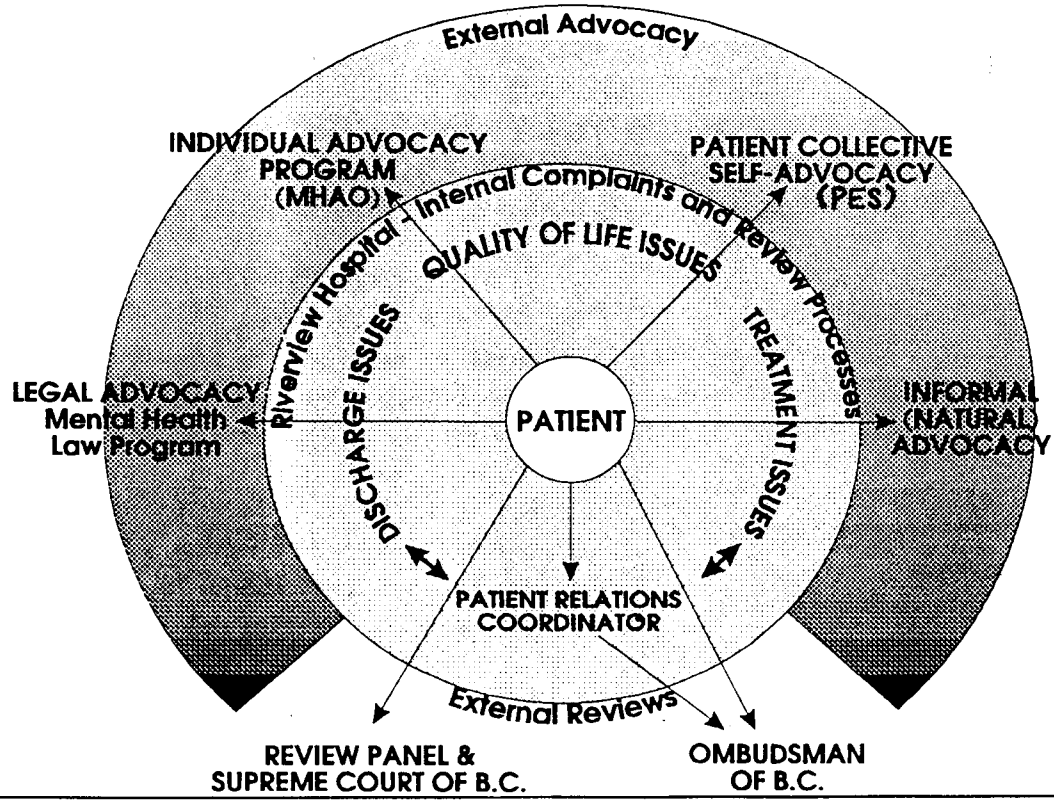
- establishing fair and clear criteria for the funding of advocacy services by non-profit societies; and
- funding services that meet established criteria, where a recognized need exists for formal advocacy, including at Riverview Hospital.

10-3 That Riverview Hospital support the development of a program of formal, non-legal advocacy for individual patients of the Hospital by authorizing Hospital staff to participate in advisory capacities to the program as invited, working with the program on protocols to facilitate the activity of its advocates, and otherwise taking steps to include and encourage the program at Riverview Hospital.

4. THE RIVERVIEW HOSPITAL FAIRNESS MODEL

This Report has focused on issues arising and response mechanisms at Riverview Hospital. It seems appropriate to conclude the Report by summarizing the future of a model of fair administration for Riverview Hospital. We do this in the form of a graphic representation which shows the interrelationship between the various issues and mechanisms of responsiveness as we have discussed them. While the diagram appears complex, it is important to recognize that most of the bodies already exist, or are in later stages of planning. The "new players" discussed in Chapter Ten, are a Mental Health Advocate for B.C., and the Individual Advocacy Program.

DIAGRAM 2: THE RIVERVIEW ADVOCACY MODEL



CHAPTER ELEVEN
SUMMARY OF RECOMMENDATIONS

Each recommendation is listed in this chapter in the order it occurred in the text. No priorities are assigned. The first digit of each recommendation number reflects the chapter where the recommendation is found, (for example, Recommendation 6-18 refers to the eighteenth recommendation in the sixth chapter).

CHAPTER TWO: FAIRNESS FOR PATIENTS - A PRINCIPLED APPROACH

2-1 That Riverview Hospital develop and implement a comprehensive implementation program of the Riverview Hospital's Charter of Patient Rights that will include staff training and familiarization of patients and families with the contents and purposes of the document. The process should include incorporation of this information in orientation materials for all new staff, patients, and families of patients.

2-2 That Riverview Hospital ensure a coordinated approach is taken to applying the Hospital's Charter of Patient Rights to particular incidents and issues within the Hospital, including an accessible system for receiving allegations of violations of the Charter, investigating into the facts, interpreting the rights contained in the Charter and applying them to the particular situation, and determining an appropriate course of action on conclusion of an inquiry. The Hospital should also use the Charter as a guide in the development and audit of all Hospital policies. Responsibility for some or all of these coordinating functions may be assigned to the recommended new position of Patient Relations Coordinator at Riverview Hospital, discussed in greater detail in Chapter Eight.

CHAPTER FOUR: LEGAL RIGHTS

4-1 That the "Guidelines for Review Panels" should be incorporated into Regulations under the ***Mental Health Act*** following the remaining consultation with interested parties including: present and former patients, families, lawyers experienced in acting for patients, community groups, representatives of Riverview Hospital, and professional groups involved in psychiatric care and treatment.

4-2 That the Ministry of Health work with the Review Panel chairpersons to develop a separate budget and purchasing arrangement for the Review Panels that would accurately reflect and reinforce its independence from Riverview or other psychiatric hospital facilities.

4-3 That the Ministry of Health revitalize the consultative process for reform of the ***Mental Health Act*** and develop new or amended legislation with vigor. That attention be given to drafting a definition of "mental disorder" that is consistent with the ***Canadian Charter of Rights and Freedoms*** and Provincial Government guidelines on inclusive language in its references to disability, and by removing "mental retardation" from the definition.

4-4 That the Provincial Government propose to the Legislature amendments to the ***Mental Health Act*** for the purpose of introducing procedural fairness into decision-making concerning the provision of psychiatric services, including:

- independent review, by Review Panel or otherwise, of assessments of patient competency to consent to treatment;
- independent review, by Review Panel or otherwise, of decisions to provide psychiatric treatment without a patient's consent;
- clarification, possibly through a definition of "treatment", that any exceptional mechanisms for obtaining consent or approval for treatment of involuntary patients extend only to psychiatric treatment.

4-5 That the Provincial Government should dedicate appropriate resources to ensure any expanded Review Panel jurisdiction can be carried out in a fair, accessible and expeditious manner.

4-6 That a Bill or Charter of Patient Rights be incorporated into British Columbia's mental health legislation to apply to all provincial mental health facilities and psychiatric units following consultation with consumers, mental health professionals and other interested parties.

4-7 That the Office of the Public Trustee designate staff positions to be responsible for receipt and processing of all financial requests regarding persons in residential care facilities in British Columbia including, but not restricted to, Riverview Hospital.

4-8 That Mental Health Services, Riverview Hospital, and the Public Trustee, in consultation with the community, produce plain language guides describing the impact of guardianship legislation on mental health care and treatment, for patients and families; and that these authorities develop standard professional practices that respect the spirit and content of the legislation, and simplify its application.

4-9 That the Provincial Government propose to the Legislature amending the ***Mental Health Act*** to make advance health care planning available to all consumers of mental health services. Pending revision of the ***Act***, that the Provincial Government propose that the guardianship legislation be amended, prior to its proclamation, to extend the same rights to persons who may become involuntary patients as it provides to all other health care consumers.

CHAPTER FIVE: QUALITY OF LIFE

5-1 That Riverview Hospital's policy on admissions be made more flexible, to permit re-admission of patients who have been recently and formally discharged or who have been long-term Riverview patients, without having to be re-admitted through psychiatric units in general hospitals.

5-2 That protocols and policies be developed by the Ministry of Health, Riverview Hospital, Mental Health Services, the Greater Vancouver Mental Health Society, and the governing bodies of acute care hospitals with psychiatric or referring emergency units, to promote the regular sharing of progress and discharge notes with respect to individual patients between the referring and treating agencies, while respecting patients' rights of confidentiality.

5-3 That in the design of any renovated or new hospital facilities on the Riverview site, the principle of maximizing privacy for individual patients be adopted, including the use of single rooms wherever feasible. This factor ought to be considered by the Ministry of Health in planning regional mental health care.

5-4 That the design of any new or renovated hospital facilities undertaken on the Riverview site and Hospital policies incorporate a maximum degree of accessibility.

5-5 That Riverview Hospital clarify and publicize its policy that kitchen areas on wards are for the use and benefit of the patients, not the staff.

5-6 That Riverview Hospital consult with the Patient Empowerment Society about ways to provide clothing to patients that are appropriate.

5-7 That the Ministry of Health and Riverview Hospital expand vocational program opportunities, and in particular, opportunities that attract incentive payments, and that the payment scale for vocational work be significantly increased. The Ministry of Social Services should exempt incentive payments paid by in-patient vocational programs from being deducted from the comforts allowance.

5-8 That the Ministry of Health and Riverview Hospital work together to develop effective education programs that assist interested patients to reduce or stop their smoking; that renovations to or redevelopment of Riverview Hospital should incorporate smoke-free living units for patients who do not smoke.

5-9 That Riverview Hospital develop a protocol with the local RCMP detachment and Crown Counsel with the goal of providing clear guidelines for police, as to when to attend and investigate and for Crown Counsel, when to prosecute allegations of criminal behaviour by patients.

5-10 That the "Patient Abuse by Staff" policy include a statement that patients who are the victims of alleged abuse which may constitute a criminal offense be advised at the outset of an internal investigation of their right to contact the RCMP.

5-11 That the "Patient Abuse by Staff" policy direct the appropriate Vice-President and the Vice President, Human and Material Resources, in consultation, or other senior administrative personnel, to consider at the outset of every investigation whether the staff member, against whom an allegation has been made, should be removed from any direct contact with the patient involved or patients generally pending outcome of the investigation.

5-12 That information about the incident investigation policy with respect to allegations of patient abuse by staff members be included in orientation materials made available to patients and their families.

5-13 That the Riverview Hospital restraint policy require that a physician must reassess the continued need for restraint at specified minimum periods of time.

5-14 That Riverview Hospital policy on chemical restraint, or "medication interventions", make reference to the need to administer medications in the least invasive manner possible, and only in association with non-threatening communication intended to explain to the patient the need for, and nature of, the medication being administered. In addition, the policy should require that the reason for the medical intervention is recorded by the physician.

5-15 That Riverview Hospital ensures that "use of restraint" records be kept by all wards on a monthly basis, using a standard format that would yield consistent and comparable data on several factors, including number of restraint incidents, nature of restraint employed, who ordered (doctor and/or nurse) and duration of restraint on a hospital-wide basis.

5-16 That in the design of any new psychiatric hospital on the Riverview site, or renovations to existing patient care buildings at Riverview Hospital, rooms used for seclusion meet the highest standards of comfort consistent with safety and privacy for patients and staff, including toilet facilities.

5-17 That Riverview Hospital seclusion policy specify that where a patient is placed in seclusion by nursing personnel pending an assessment and order of seclusion by a physician, that the nurse in charge co-sign the seclusion order.

5-18 That Riverview Hospital develop standards for locked wards and criteria for deciding when it is appropriate to transfer a patient to a locked ward. Informal patients should not be transferred to locked wards unless their status has first been reassessed and changed to involuntary.

5-19 That in addition to monitoring the use of restraint measures, Riverview Hospital keep records on the frequency, duration and reasons for restricting patients to pajamas.

5-20 That Riverview Hospital develop a process to receive and respond to complaints by patients who feel that they have been unfairly or inappropriately restrained, including where they had grounds or clothing privileges restricted. The process should respect the principles of administrative fairness and therefore involve a review of the decision to restrain or restrict "privileges", and should permit the patient to be heard. Information about the review process should be included in orientation materials for both patients and families, and be posted on all wards.

5-21 That the Ministry of Health engage in a consultative process to examine ways in which decisions to use physical and mechanical restraints, and seclusion, in psychiatric hospitals could be made subject to review by the Review Panel or other administrative tribunal.

CHAPTER SIX: TREATMENT CONCERNS AND REVIEW MECHANISMS

6-1 That the Ministry of Health provide additional funding to Riverview Hospital for the purpose of expanding counselling and psychotherapy services for Hospital patients, particularly in the area of sexual abuse counselling for patients/survivors, and that the Hospital incorporate these services into its clinical programs.

6-2 That Riverview Hospital develop a policy which enables clinicians to seek consultations from colleagues both inside and outside the Hospital.

6-3 That Riverview Hospital direct the Medical Quality Assurance Committee to review its mandate and the way it operationalizes its mandate given the need to review clinical practices absent patient complaints.

6-4 That Riverview Hospital develop protocols with professional associations governing clinical personnel at the Hospital with respect to referral of, and reporting back on, matters with the potential for professional discipline; in particular, that Hospital policy require referral of any allegation of sexual abuse of a patient by a staff member to their governing professional body, in addition to any internal recourses or referrals to police authorities; and that Hospital policy clarify the reporting relationships between clinical departments and senior administration on matters of potential misconduct.

6-5 That Riverview Hospital revise its policy on patient access to her or his own clinical records to ensure that it is consistent with common law and the ***Freedom of Information and Protection of Privacy Act,*** and in particular, to remove unnecessary barriers to access such as the requirement to provide reasons for the request or the strict enforcement that the request be in writing.

6-6 That Riverview adopt a single standard form for recording the essential features of an integrated patient centered plan of care. These features include:

- diagnosis;
- modalities of treatment (medications, special behaviour programs, skills acquisition programs, etc.);
- explanations of what each modality intends to accomplish and how;
- prognosis;
- discharge plan;
- a section for patient input and signature; and,
- patient goals and outcomes.

This form should be included in the progress notes on the patient's chart, and be available to the patient and Hospital personnel involved in treatment or responsible for reviewing treatment. When a patient is illiterate, marginally literate, visually impaired, blind or unable to read, the plan should be read and explained to them verbally or made available on audio-cassette tapes.

6-7 That Riverview Hospital develop a standard process for receiving and responding to patient requests to change care-givers, with the ability to limit the number of requests over time, on the basis of what is fair and reasonable in the circumstances.

6-8 That the Ministry of Health and Riverview Hospital develop a program that would permit Hospital patients to obtain a second medical opinion on request. The program would have the following features:

- a standard and plain language form for initiating the request;
- recognition of the patient's right to name a qualified psychiatrist from whom an opinion will be sought, subject to availability and her or his agreement to do so;
- recognition of the patient's right to receive a copy of the opinion;

- payment by the Medical Services Plan for patient-requested second opinions, in particular for non-staff clinicians; and,
- reasonable limits on the intervals between second opinions obtained at the request of an individual patient, in light of factors such as the seriousness or invasiveness of the treatment proposed (for example, no limits on second opinions for recommended courses of treatment for of Electro-convulsive Treatment).

CHAPTER SEVEN: LEAVING RIVERVIEW

7-1 That the British Columbia Buildings Corporation engage in a process of open public consultation with respect to the future use or sale of the Riverview grounds before any decisions are made on that subject.

7-2 That Riverview Hospital consult in a timely and meaningful way with patients and consumers of community mental health services in the planning of bed closures.

7-3 That Riverview Hospital adopt policy that sets basic standards for discharge planning, including:

- that the discharge planning process begin as soon as practicable following a patient's admission to the Hospital;
- that the patient be involved at every stage, and that family members be involved, subject to the patient's agreement; and,
- a checklist of items that require attention for every patient; when a patient is discharged without an item having been dealt with, an explanatory note would be written.

7-4 That the Ministry of Social Services create a position for a transition staff person to Riverview Hospital, at a Supervisor level, possibly stationed at the Coquitlam District Office of the Ministry or on the Hospital grounds. Responsibilities would include taking applications for GAIN and GAIN for Handicapped from patients, liaising with Ministry Offices around British Columbia, coordinating the exchange of information where appropriate and preparing educational materials to sensitize Ministry of Social Services staff to the needs of patients returning to their home communities.

7-5 That Riverview Hospital and the Ministry of Social Services develop a protocol to facilitate the exchange of information on patients admitted to and discharged from the Hospital, while respecting patients' rights of confidentiality and privacy.

7-6 That identification necessary to apply for income assistance and other social services be provided and obtained for patients admitted to Riverview Hospital without such identification, either through the creation of a fund to pay the costs of obtaining identification, or by waiving those costs for hospitalized patients, through a coordinated effort by Riverview Hospital and the Ministry of Social Services.

7-7 That Riverview Hospital provide patients (in advance of discharge) with a "letter of introduction" to Ministry of Social Services offices that would contain information needed to open an income assistance file, including employability status if appropriate.

7-8 That the Provincial Government establish a fund to provide a transitional cash payment of up to $200 to discharged patients leaving Riverview Hospital.

7-9 That the Provincial Government work with municipalities and the housing development sector to greatly expand the quantity and diversity of low-cost housing options available to persons with mental illness, especially those discharged from Riverview Hospital. Particular emphasis should be placed on expanding semi-independent or interdependent housing opportunities.

7-10 That Riverview Hospital and other relevant authorities study expanding transitional and emergency housing opportunities for discharged patients on Hospital grounds.

7-11 That Riverview Hospital provide all patients prior to discharge with an information kit that gives information in plain language on how to live successfully in the community, including:

- medications and side-effects;
- addresses and phone numbers of community mental health and other support services;
- how to obtain identification if lost after discharge; and,
- how to open a bank account and do basic budgeting.

7-12 That the Ministry of Health and Riverview Hospital improve the quality of transportation and supports for patients traveling to their home destinations.

7-13 That the Ministry of Health fund pilot projects that would bring groups of former patients into Riverview Hospital to meet with

patients to exchange information on living successfully in the community following discharge.

7-14 That Riverview Hospital include in its discharge planning a referral to local advocates in the locality where the patient will be living following discharge. This could be included in the discharge survival kit. (See Recommendation 7-11.)

7-15 That Riverview Hospital policy state that every patient who has scheduled a Review Panel hearing be advised that should the Review Panel order them decertified, they are welcome to remain in Hospital on an informal basis while community arrangements are made.

7-16 That the Ministry of Health and Riverview Hospital review ways to improve short-term discharge planning for patients decertified by Review Panel order, including assigning a duty social worker to cover evenings or have Panels to sit only in the daytime.

7-17 That the Ministry of Health provide resources to permit, and with Riverview Hospital encourage, visits by Mental Health Centre and Team staff to follow clients recently admitted to Riverview Hospital and meet with patients who will be discharged to their catchment areas.

7-18 That the Ministry of Health and Riverview Hospital actively explore ways to increase opportunities for staff exchanges between the Hospital and community mental health services.

CHAPTER EIGHT: A RESPONSIVE RIVERVIEW

8-1 That Riverview Hospital adopt a policy on complaints that incorporates the principles of administrative fairness, including accessibility, simplicity, investigative responsibility that is independent, written acknowledgment and response, a third party complaints process and an internal appeal.

8-2 That Riverview Hospital create a senior administrative position of a Patient Relations Coordinator (PRC) to assume responsibilities for coordinating the complaints-handling process at Riverview Hospital, including but not limited to:

- monitoring and supporting policies and processes that are intended to expand the participation of and communication with patients and family members in Hospital activities, (such as ward meetings and implementation of the Hospital's Charter of Patient Rights);
- reporting regularly to the Board of BCMHS on results, problems, and opportunities in the PRC's areas of responsibility; and,
- acting as liaison with the Office of the Ombudsman and any other external agencies with respect to patient complaints matters.

8-3 That Riverview Hospital develop a "How to Complain", or "How to Be Heard" brochure for patients and families that outlines, in plain language, how a patient can make a complaint. Included should be examples of the types of complaints that can be made, and how complaints are responded to, as well as referring to available sources of advocacy support.

8-4 That the Attorney General table an amendment to ***Ombudsman Act*** as soon as possible to create a specific exception to section 57 of the ***Evidence Act*** for the purpose of Ombudsman investigations making clear that release of the report to the Ombudsman does not waive the privilege provided to hospitals by section 57.

CHAPTER NINE: EXISTING ADVOCACY RESOURCES

9-1 That Riverview Hospital review the recommendations made in "What Families Want From Riverview" dealing with major family concerns to see which still remain to be acted upon and develop an action plan.

9-2 That training be made available to Riverview staff sensitizing them to the needs of family members, and how to respond helpfully to their inquiries, input and comments.

9-3 That procedures be developed to ensure that family members are advised of all significant changes in a patient's care, including medications, physicians, legal status, and decisions to discharge the patient, subject to the patient's rights to limit or refuse disclosure, and that families know who they can contact with questions. This information ought to be provided in the family's orientation package.

9-4 That the present schedule of regular reporting to a patient's family be reviewed for its adequacy, and that families be advised on the admission of a relative of their opportunity to have meetings with the treatment team at regular intervals.

9-5 That Riverview Hospital staff know how to access existing Provincial funds to support family members' travel costs for visits to Riverview Hospital and that they inform family members of these procedures. Where a patient has been served in her or his local community and intends to return, this continuity of natural support provided through visits, is critical.

9-6 That ward and program staff at Riverview Hospital plan more opportunities to include interested family members in patients' activities.

9-7 That Riverview Hospital staff be available to receive advice, concerns and input from family members, even when a patient has refused to consent to the disclosure of personal information to their family members.

9-8 That family members who are denied information, on the grounds that the patient has refused to permit disclosure, be advised of their ability to make a complaint to the Hospital (PRC) so that the matter can be reviewed.

9-9 That Riverview Hospital administration develop a specific policy outlining the role of staff as front-line advocates and confirm the Hospital's present understanding that retribution of staff for participation in advocacy efforts will not be tolerated.

9-10 That Riverview Hospital include in its orientation materials an explanation regarding the protection against retribution for contacting the Ombudsman as provided for in the ***Ombudsman Act.***

9-11 That Riverview Hospital adopt a policy that expressly authorizes staff members to refer patients to available formal advocates.

9-12 That the Ministry of Health appoint at least one former patient of Riverview Hospital as a trustee on the BCMHS Board.

9-13 That Riverview Hospital develop a protocol to permit representatives of designated consumer organizations general access to wards during visiting hours and other pre-arranged times.

9-14 That individuals or advocacy groups denied access to patients be advised of their ability to file a complaint to have the matter reviewed to the internal complaints process.

9-15 That Riverview Hospital take steps to encourage wards and other programs in the Hospital to invite representatives of consumer advocacy groups from the community to speak at gatherings of patients, and that the Hospital monitor the frequency with which this happens.

9-16 That Riverview Hospital develop opportunities to bring consumer advocates from the community together with Hospital administrators and staff, including inviting advocates to sit on Hospital policy and planning committees, and by having staff and advocates work jointly on patient information programs, such as discussions on living successfully in the community with soon-to-be-discharged patients.

9-17 That Riverview Hospital policy refer to facilitating contacts between patients and consumer advocacy organizations as a part of discharge planning.

9-18 That the Office of the Public Trustee, the Ministry of Health, and Riverview Hospital ensure the preparation of plain language information kits for the use of persons who may wish to consider applying for substitute decision-maker status with respect to a hospitalized patient under the new guardianship legislation. Contained in the package should be information on how individuals can act as advocates for patients as an alternative to seeking appointment as a substitute decision-maker or guardian.

9-19 That the Attorney General in consultation with the Legal Services Society consider ways of expanding the availability of legal advocacy to patients, particularly those hospitalized outside the Lower Mainland, including representation before the Review Panel or on section 27 Court applications, in whole or in part, on the legal aid tariff.

9-20 That Riverview Hospital adopt policy establishing minimum requirements for ward community meetings, including:

- a minimum frequency;
- meetings to be chaired by a patient, or co-chaired by a patient and PES, or, when a patient is not available, chaired by PES;

- minutes of meetings to be typed, kept posted on the ward, and copies forwarded to Directors of Nursing for each Program, the Patient Empowerment Society and the Patient Relations Coordinator;
- meetings to begin by reviewing previous meeting's minutes; and,
- a regular agenda item for issues or complaints of patients, and for updates on responses to issues and action taken raised at earlier meetings.

9-21 That Riverview Hospital and the Patient Empowerment Society undertake a process to identify the kinds of issues that could be delegated for decision by patients at ward meetings.

9-22 That Riverview Hospital provide education and instruction for staff and patients on constructive meeting formats to encourage and maximize participation and consider development of an instruction manual to that end.

9-23 That Riverview Hospital adopt policy that recognizes and affirms the legitimate role of a patient advocacy body run by present and former patients, and independent of the Hospital's governing authority, in representing a collective voice of patients and engaging in advocacy on systemic issues of concern to Hospital patients.

9-24 That Riverview Hospital work with a patient-run advocacy body to develop protocols covering such issues as the use of facilities on hospital grounds for office and meeting space, and a flexible, effective and meaningful communication and reporting relationship between the Hospital and that body.

9-25 That Riverview Hospital adopt a policy encouraging staff involved in patient care to be supportive of, and respectful toward the participation of individual patients in collective patient advocacy.

9-26 That Riverview adopt policy stating that all patients who wish to attend regularly scheduled meetings of the patient-run advocacy body have the right to do so, including the right to be escorted if they do not have ground privileges, unless their attendance would constitute a real danger to self or others, which reasons are to be documented by the attending physician.

9-27 The Riverview Hospital adopt policy stating that patients who attend regularly scheduled advocacy meetings be compensated for the time away from their usual vocational work placement.

9-28 That the complaints process and treatment review mechanisms discussed earlier in this report be made available to individual patients who believe treatment decisions are unfairly or unreasonably restricting their patient advocacy activities.

9-29 That pending any decision to coordinate the funding of a range of advocacy activities through other Ministries or branches of the Provincial Government, or through non-profit public interest agencies in the community, the Ministry of Health provide core funding for the activities of the patient advocacy body at Riverview Hospital.

CHAPTER TEN: A PROVINCIAL FRAMEWORK FOR INDIVIDUAL ADVOCACY

10-1 That the Provincial Government appoint a Mental Health Advocate for the Province of British Columbia, with the following mandate:

- to report annually and as required to the public on the state of the mental health service system in B.C., and on the issues being encountered by consumers, service providers, advocates, and those they support; and
- to provide a single information and referral source for advocacy resources in mental health services in B.C.

That the model be based on a consultation with community organizations and that the Ministry of Health make a proposal for the model within 2 to 3 months of this Report.

10-2 That in addition to appointing a Mental Health Advocate, the Provincial Government, in consultation with Riverview Hospital and community advocacy organizations, support the creation of a network of advocacy services for individual consumers of mental health services, including a program for non-legal advocacy for individual patients at Riverview Hospital, by:

- establishing fair and clear criteria for the funding of advocacy services by non-profit societies; and
- funding services that meet established criteria, where a recognized need exists for formal advocacy, including at Riverview Hospital.

10-3 That Riverview Hospital support the development of a program of formal, non-legal advocacy for individual patients of the Hospital by

authorizing Hospital staff to participate in advisory capacities to the program as invited, working with the program on protocols to facilitate the activity of its advocates, and otherwise taking steps to include and encourage the program at Riverview Hospital.

APPENDIX I

RIVERIVEW HOSPITAL
CHARTER OF PATIENT RIGHTS

PREAMBLE

The Board of the British Columbia Mental Health Society is pleased to endorse the Charter of Patient Rights outlined below as a framework for patient care at Riverview Hospital. In support of this Charter of Patient Rights, the Hospital will undertake all reasonable efforts to ensure these rights are exercised while recognizing the rights of others, and in conformance with existing legislation.

PART I QUALITY OF LIFE/SOCIAL RIGHTS

Social rights emphasize the rights of the patient rather than administrative/organizational convenience, and aim to avoid a system of control that may become dehumanizing. These rights are to be interpreted within the Hospital's responsibility to provide a safe and therapeutic environment for all patients within the available resources. These rights include economic assistance, privacy, confidentiality, security of person and property, recognition of individuality, access to religious services, freedom of social contact and communication in the language of choice.

Each patient has:

1. The right to a safe and secure environment.
2. The right to considerate and respectful care.
3. The right to be treated with dignity and respect at all times. This right applies also to patients' family members, significant others and friends.
4. The right to an appropriately prompt, reasonable and courteous response to requests for services or information.
5. The right to an interpreter when needed.
6. The right to be provided with sufficient, nutritious and palatable food, with consideration given to religious and medical requirements.
7. The right to receive a written monthly statement, as well as at the time of discharge, of deposits, withdrawals and balance of account(s), and a written receipt and account balance for all deposits and withdrawals.
8. The right to meet with clergy or other spiritual advisors, as promptly as possible.
9. The right to privacy including during visits and in the sleeping environment provided this doesn't create a risk for the patient or others.
10. The right of liberal access to family members, significant others and friends.
11. The right to privacy for sexual activity between adult patients subject to capacity to consent and to engage in safe sexual practices.
12. The right to education regarding communicable diseases including sexually

transmitted diseases, and the right to confidential access to prophylactics to assist in the prevention of communicable diseases.

13. The right to a quiet sleeping environment.
14. The right to wear personal clothing at any time while hospitalized unless deemed to be an elopement risk.
15. The right to uncensored and unobstructed communication by telephone, letter or in person with any willing party.
16. The right to retain and use personal clothing, money and possessions with access to secure storage, unless this poses a risk to the patient or others.
17. The right upon discharge:
    a) to have two business days notice;*
    b) to notify the person of choice;
    c) to have appropriate help in finding suitable housing and community resources; and
    d) to be informed of follow-up medical care and support and to have assistance in arranging it;
    e) when a patient agrees to a planned discharge, hospital staff will make sure such a discharge does not occur until issues of finance, housing and community clinical care are addressed.
18. The right to choose and be provided with recreational and educational activities.

* Where the discharge is ordered by the Review Panel, two business days notice is not possible.

19. The right of generous access to the out-of-doors daily. Normally, this will be no less than 90 minutes unless this puts the patient or others at risk or if staffing is not sufficient.

20. The right of spouses to share a room if both are patients, if both are agreeable, if a private room is available in an appropriate ward and if it is deemed to be clinically appropriate for both spouses.
21. The right to be provided with all possible assistance in ensuring that financial support from appropriate agencies during hospitalization and upon discharge is obtained.
22. The right to a volunteer, as promptly as possible.

PART II QUALITY OF CARE/THERAPEUTIC RIGHTS

Therapeutic rights emphasize the right of patients to be involved in treatment decisions. Patient involvement in treatment decisions involves the right to be fully informed of treatment options and voluntary patients to give consent freely. This enhances the patient's ability to strive toward improve health and to make a commitment to a post-discharge treatment plan.

This approach includes consideration of therapeutic alternatives, second medical opinions, choice of caregiver, clinical safeguards, information about treatment, access to caregiving persons, discharge plans and adequate supervision.

APPENDIX II

RIVERVIEW HOSPITAL SERVICE FEEDBACK FROM PATIENTS/CITIZENS

POLICY

It is the policy of Riverview Hospital to value all verbal or written service feedback by a patient, family member or other citizen as a valuable opportunity for continuous quality improvement. All concerns and complaints will be investigated in a fair, objective and prompt manner. Every attempt to achieve both an early and full resolution will be made by all staff.

PURPOSE

The purpose of this policy is to define a standardized process for ensuring that all aspects of service feedback are investigated thoroughly, and that every individual providing service feedback receives a complete and accurate response on behalf of the Hospital in a prompt manner. It is the responsibility of all staff to identify and assist in resolving patient and citizen concerns and complaints.

PROCEDURE

1. Service feedback can be received either verbally or in written form. Interpretation services will be made available, if necessary, to the complainant. Any staff member who receives a complaint will attempt to resolve the issue promptly.
2. If unresolved within five (5) working days, a Service Feedback Form will be completed by the complainant and staff members. The original will be retained by the complainant with copies sent to Department Manager/Head Nurse who investigates the complaint and the Coordinator of Patient Relations. In the case of a complaint to a Physician, the copy will be sent to the appropriate Program Director and the Coordinator of Patient Relations.
3. An acknowledgement letter will be sent to the complainant by the Program Director/Department Manager/Head Nurse within five (5) working days.

4. The Coordinator of Patient Relations may be involved in the process to assist in resolution.
5. The complainant will be informed in writing of the action taken and/or the final outcome of the investigation within 20 working days of the receipt of the service feedback.
6. The Service Feedback Form is regularly updated by the Program Director/Department Manager/Head Nurse.
7. Data collected on completed responses to service feedback will be recorded quarterly by the Program Director/Department Manager/Head Nurse and forwarded to the Coordinator of Patient Relations.
8. Quarterly reports will be provided on service feedback by the Coordinator of Patient Relations to Management Committee with a copy to the Manager, Quality Management. These reports will include recommendations for policy, procedure and organizational structure changes.
9. If a complainant is not satisfied with the response received, the following process will be used:
   - The complainant will contact the President's Office.
   - In reviewing the service feedback, the President will make every effort to talk to all the relevant persons, including the person who provided the service feedback. The latter may wish to bring a family member, friend or advocate for this discussion.
   - The President will respond in a prompt manner to the complainant.
10. Staff receiving service feedback that may require the advice of a lawyer will consult with the President's Office.
11. Service feedback received by a Trustee will be referred to the President for review, response and appropriate follow-up.
12. All concerns and complaints will be treated confidentially except where disclosure is necessary to complete the investigation. Where disclosure is necessary, the consent of the complainant will be obtained.

Each patient has:

1. The right to receive prompt and appropriate care and treatment provided by appropriately trained staff.
2. The right to know the full identity and professional status both of ward staff and other staff providing services at Riverview Hospital.
3. The right to expect a reasonable continuity of caregivers.
4. The right to choose caregivers and care environment where possible.
5. The right to a second medical opinion and to have hospital staff facilitate the obtaining of this opinion.
6. The right to be involved in discharge planning from the time of admission.
7. The right to be fully informed of all reasons, benefits and risks involved in any proposed transfer.
8. The right to be informed, upon discharge, of continuing treatment requirements, and to have every reasonable effort made to ensure these are met.
9. Prior to giving consent to any treatment, but in conformance with the Mental Health Act:
   a) the nature and type of any treatment planned and how it may work;
   b) the likely benefits of the treatment;
   c) the common and likely side-effects, adverse reactions or risks of the treatment;
   d) the known and safe treatment options; and,
   e) the potential risks and benefits of refusing treatment.
10. The right to receive reasonably full and complete information concerning treatment in terms and language that can reasonably be expected to be understood.
11. The rights to be free from chemical and physical restraint, except in an emergency where it is necessary to protect the patient from injury to self or others. The physician must have authorized this restraint for a specified and limited period of time.
12. The right to be free from experimental and/or controversial procedures unless informed consent is given.
13. The right to give consent freely without any external pressure or coercion, unless otherwise mandated by law.

PART III SELF-DETERMINATION/LEGAL RIGHTS

When a person is admitted involuntarily to a psychiatric hospital, a number of civil and human rights may be taken away. An involuntary patient has a right to be informed of the reasons for detention and of the available review process. Self-determination includes the right to be informed before giving consent, but in conformance with the Mental Health Act, access to clinical records, legal rights information, review of committal, access to legal services, incompetency determination when required, review of compulsory treatment and restraint.

Each patient has:

1. The right not to be detained unless the rules of natural justice and fair procedure are

followed.

2. The right of access to free legal advice, counsel or advocacy on request.
3. The right not to be impeded from choosing a lawyer to provide representation at review panels that consider the matter of involuntary detention.
4. The right immediately upon admission, or as soon thereafter as the patient can reasonably understand, to be fully informed of the relevant Riverview Hospital rules and regulations, legal rights and the Charter of Patient Rights, including the right to a Review Panel or court hearing under the Mental Health Act. This information must be provided on an ongoing basis, at least every three months, and be presented in a manner and language that can be understood.
5. The right to see his/her hospital record, to attach a statement of corrections and have specific parts of the record copied, without charge, unless harmful to third parties or self.
6. The right to have all communications and records pertaining to care while hospitalized shared only with persons directly involved with medical and psychiatric treatment of the patient, except where required under law.
7. The right, if eligible, to vote in any municipal, provincial, or federal election, and to be fully notified of the date, time and place of enumeration and voting and to receive any necessary assistance in being enumerated and in travelling to the polling station, if on hospital premises.
8. The right not to be subjected to any form of cruel and unusual treatment or punishment. This is guaranteed under the Canadian Charter of Rights and Freedoms and the United Nations' Universal Declaration of Human Rights.
9. The right to be provided with a written copy of the Riverview Hospital Charter of Patient Rights and to have it posted in every patient dayroom and at every main building entrance.
10. The right of access to an organization independent of Riverview Hospital to investigate alleged violations of these patient rights.

Nothing in this document prevents Riverview Hospital from recognizing patients' additional rights including those protected by the Canadian Charter of Rights and Freedoms and the Universal Declaration of Human Rights. This document will be reviewed annually through a consultative process involving patients, former patients, patient advocacy organizations, family members, staff and other stakeholder groups.

February 1994