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## 2014-2015 Annual Report

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Letter to the Minister of Health

The Honourable Sarah Hoffman
Minister of Health
423 Legislature Building
10800 97 Avenue
Edmonton, AB Canada T5K 2B6

Dear Minister Hoffman:

It is my responsibility and honour to present the Alberta Mental Health Patient Advocate Annual Report for 2014/2015 as we celebrate our 25th year serving Albertans. The report summarizes my activities to support persons to understand and exercise their rights under the Mental Health Act and to investigate complaints from or related to persons who are under one or two admission or renewal certificates or a community treatment order.

This report is submitted in accordance with the provisions of Section 47(1) of the Mental Health Act for your presentation to the Legislative Assembly.

Respectfully submitted,

(Signed by Carol Robertson Baker)
Mental Health Patient Advocate
Focus of the Office of the Alberta Health Advocates

The Office of the Alberta Health Advocates consists of the Mental Health Patient Advocate and the Health Advocate. Albertans contact us to share their stories about their health care journey and experience. Collective action taken by the Advocates ensures rights are protected, concerns are resolved, and that the quality and patient safety of the Alberta health system is enhanced.

Vision

We envision an integrated and responsive system that empowers and supports Albertans as full participants in their care and fairly addresses their concerns about services that impact health.

Mission

We assist Albertans in dealing with concerns about services impacting their health, and becoming empowered and effective advocates.

Values

Respect  Engagement  Compassion  Integrity  Excellence
Message
from the Mental Health Patient Advocate

There is an old saying that goes “without hope the heart would break.” Compassion, hope and help are at the core of what the Alberta Mental Health Patient Advocate and staff do as we empower people touched by mental illness to be partners in their care to the best of their ability, even when there are limitations due to their mental illness.

This year marks the Mental Health Patient Advocate’s 25th anniversary in assisting Albertans in their journey of recovery. Looking back over the years, while much has changed in the mental health system, we continue on our path as advocates to instill hope for this often vulnerable population who fall under the Mental Health Act. We do so by giving them a voice, helping them to exercise and understand their rights enshrined under the Act, impartially investigating and resolving complaints, and making recommendations to not only improve the individual’s treatment and care but to improve the mental health system.

We are uniquely positioned to provide our clients’ perspective in the development and implementation of mental health policies and procedures. We also advocate for amendments to mental health and other protective legislation that impact our clients. Through this and by providing education services, many individual lives have been transformed and the mental health community has been strengthened.

The past year posed challenges to fulfill our legislative mandate in a timely manner. This was largely due to the loss of a position and the subsequent reassignment of duties, along with the Government of Alberta’s restraint measures. It had a direct impact on the number of Albertans we served and the comprehensiveness of our investigations. Nonetheless, we opened a total of 1,421 new case files, generating 4,300 issues or requests, which meant more than 8,000 contacts with Albertans.

As in previous years, our clients shared concerns with us about respect for their enshrined rights and the consistent application of the Act. Although there has been some progress in this area, there is still more work to do to protect patient rights. Other issues we heard pertained to patient-centred care, seclusion and restraint, and in-patient overcapacity beds, to name a few. Although these issues were resolved at the
individual level, work is on-going to address these issues at a systemic level. I am proud to say that over the past year we have built a stronger systemic advocacy network with numerous partners in mental health, education, corrections, community organizations, cross-ministries, and at various levels of government. Some of these initiatives are featured in this report.

The coming year is significant for mental health in Alberta with two reviews. The Standing Committee on Families and Communities will be reviewing the 2009 and 2010 amendments to the Mental Health Act. There is also the Mental Health Review Committee that will conduct a comprehensive review of Alberta’s addiction and mental health system. The Committee will report and make recommendations to the Alberta government that will strengthen the system. I look forward to participating in both reviews.

We will also focus our path on building our website and resource materials to better enable understanding of the Act and its impact on our clients; providing opportunities for my staff to apply their newly-acquired mediation skills; ensuring accountability up the line for the protection of patient rights and the consistent application of the Act; exercising the Mental Health Patient Advocate’s full authority under the Act to conduct comprehensive investigations with or without a complaint; and strengthening the operations of the Office of the Alberta Health Advocates. This can only be achieved with sufficient resources in place.

To all of our valued clients and their families, I would like to express my gratitude for touching our lives by sharing your experience with us, guiding us in the work we do, and providing suggestions on how to improve the mental health system. I would like to extend a sincere thank you to the caring, professional support my staff provided to individuals living with a mental illness and to their families and care givers. To the Health Advocate, the Seniors’ Advocate, and all of the health care and community support providers, I would like to thank you for your commitment to ensure all people touched by mental illness receive the very best treatment, care, and support during their journey of recovery. Collectively, we can make a difference in the lives of Albertans.

Carol Robertson Baker
Alberta Mental Health Patient Advocate
Mental Health Patient Advocate

Commemorates 25 Years of Serving Albertans

On January 1, 1990, the Mental Health Act of Alberta was proclaimed. It established the first Mental Health Patient Advocate (MHPA) in Canada legislated to assist formal patients detained in hospital against their will under either two admission or two renewal certificates, and also those acting on their behalf.

The office of the MHPA was established in order to provide protection for patients’ rights as explained by the then Minister of Health, the Honourable Marvin Moore, during second reading of the bill amending the Mental Health Act. He stated:

“For many years people in the field of mental health in our province and across Canada have been lobbying for mental health patient advocate offices to be established, an individual with appropriate staff and finances to be able to be an advocate for involuntary mental health patients. This legislation, for the first time in Alberta, provides for the establishment of that office.” (Hansard; May 30, 1988)

In 2009, the Act was amended to expand the Advocate’s jurisdiction to include persons subject to a single admission certificate. In 2010, the MHPA’s jurisdiction was further expanded to include persons subject to a community treatment order (CTO). CTOs were introduced to help persons with serious and persistent mental disorders who have experienced repeated hospitalization, and have demonstrated that they need community support and treatment to live successfully in the community.

Our long and distinguished history of serving people touched by mental illness has ensured their voice is heard in matters that impact their lives, that they understand and exercise their rights if they choose to do so, and that there is a fair resolution to their concerns. We are proud to report that we have also impacted health policies and procedures as well as protective legislation through our reports, submissions and recommendations. Many of our recommendations for amendments to legislation have been accepted and can be found in the Mental Health Act, Alberta Health Act, Adult Guardianship and Trusteeship Act, Personal Directives Act, Health Information Act, and the Protection for Persons in Care Act.

I would like to extend my heartfelt thanks to patients and their families who have contacted us over the years for help. The stories you have shared about your experience have helped to improve the system. I would also like to thank the countless inter-disciplinary teams, Government of Alberta cross-ministry teams, community organizations and others who have welcomed and collaborated with our office to ensure those living with a mental illness receive the very best treatment and care, that their voice is heard and considered in matters impacting their life, and that their rights are respected. Finally I would like to extend my gratitude to the Government of Alberta for their early commitment and investment in protecting the rights of this often vulnerable and disadvantaged population, and for legislating the Mental Health Patient Advocate under the Mental Health Act to help people touched by mental illness.

I would be remiss not to acknowledge and express my sincere appreciation to my predecessors and to the current and former staff of the Mental Health Patient Advocate.
Advocate for their steadfast dedication and relentless effort to help our clients by providing them with encouragement, hope and support. We have come a long way in ensuring the patient and family voice is heard.

Below is a list of the Mental Health Patient Advocates since 1990. I have had the honour and privilege of knowing and learning from Merv, Jay, Sandra, and Fay. Your mentorship has been invaluable to me. Thank you for your dedication to helping those living with a mental illness in their journey of recovery.

Dr. Merv W. Hislop (1990 to 2002)  
Jay McPhail (2002 to 2006)  
Sandra Harrison (2006 to 2010)  
Fay Orr (2010 to 2014)  
Carol Robertson Baker (2014 to Present)

### Mental Health Patient Advocate (MHPA) Yesterday and Today

<table>
<thead>
<tr>
<th>1990</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 designated facilities under the <em>Mental Health Act</em></td>
<td>20 designated facilities under the MHA</td>
</tr>
<tr>
<td>Approximately 250 formal patients under the MHA in designated facilities across Alberta at any given time from January 1, 1990 to December 31, 1990</td>
<td>9,374 distinct individuals receiving mental health services at inpatient hospitals, certified under the MHA, from April 1, 2014 to March 31, 2015. The number of CTOs issued to individuals for the first time in 2014/15 was 428.</td>
</tr>
<tr>
<td>MHPA jurisdiction includes patients subject to two admission or two renewal certificates (formal patients) and those acting on their behalf</td>
<td>MHPA jurisdiction includes patients subject to a single form 1 admission certificate, formal patients, persons subject to a community treatment order, and those acting on their behalf</td>
</tr>
<tr>
<td>350 total number of MHPA files</td>
<td>1,421 total number of MHPA files</td>
</tr>
<tr>
<td>1,691 total number of contacts</td>
<td>8,352 total number of contacts</td>
</tr>
<tr>
<td>770 total number of issues/requests</td>
<td>4,300 total number of issues/requests</td>
</tr>
<tr>
<td>Issues largely pertain to involuntary detention and treatment</td>
<td>Issues largely pertain to involuntarily detention/rights and treatment/care</td>
</tr>
<tr>
<td>34 presentations targeting designated facilities, agencies, organizations and government departments</td>
<td>60 presentations targeting those with lived experience, health care providers, Government of Alberta departments, lawyers, community organizations, people involved in concerns resolution, and post-secondary students</td>
</tr>
<tr>
<td>Staff includes one Assistant Patient Advocate, one Patient Advocate Representative and one administrative assistant</td>
<td>Staff includes two Patient Rights Advocates. An administrative assistant position is shared.</td>
</tr>
<tr>
<td>Mental Health Patient Advocate Office is a stand-alone office. MHPA budget is $358,518.</td>
<td>MHPA and staff are part of the Office of the Alberta Health Advocates. MHPA budget is $955,000.</td>
</tr>
</tbody>
</table>
“The Advocate helped me with my appeal by giving me the information I needed.”  
*Formal Patient*

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# Rights

of Persons Under the *Mental Health Act*

The Mental Health Patient Advocate helps Albertans to understand and exercise their rights under the *Mental Health Act* (MHA). A person's rights depend on that person's legal status under the MHA.

Many of the rights enshrined in the MHA flow from the Canadian Charter of Rights and Freedoms. They provide important checks and balances to help prevent anyone from being wrongfully detained and to protect the legislated rights of this often vulnerable population.

Having to be examined and admitted to hospital because of a mental illness or being under a community treatment order can be a difficult and confusing experience for individuals and their families. A list of some of the rights for patients under formal status and for persons under a community treatment order can be found on page nine. A complete summary of MHA rights information can be found in ten different languages on our website at [www.albertahealthadvocates.ca](http://www.albertahealthadvocates.ca)
Rights of a formal involuntary patient (someone who is subject to two admission or renewal certificates) include:

- **THE RIGHT** to be told verbally and in writing the reason for one’s involuntary detention in hospital
- **THE RIGHT** to a copy of one’s admission or renewal certificates
- **THE RIGHT** to a lawyer
- **THE RIGHT** to refuse treatment unless deemed mentally incompetent
- **THE RIGHT** to appeal one’s admission/renewal certificates or the certificate of incompetence to a Review Panel
- **THE RIGHT** to appeal Review Panel decisions to the Court of Queen’s Bench
- **THE RIGHT** to have one’s health information kept confidential
- **THE RIGHT** to be told that their CTO has ended
- **THE RIGHT** to contact the Mental Health Patient Advocate

The legal guardian of a person detained under the MHA has the right to be notified of the reasons for the detention and to receive copies of the certificates. The nearest relative also has these rights, unless the patient objects.

Rights of a person subject to a community treatment order (CTO) include:

- **THE RIGHT** to receive information about their CTO
- **THE RIGHT** to a lawyer
- **THE RIGHT** to apply to the Review Panel to cancel their CTO
- **THE RIGHT** to appeal any Review Panel decision to the Court of Queen’s Bench
- **THE RIGHT** to have one’s health information kept confidential
- **THE RIGHT** to be told that their CTO has ended
- **THE RIGHT** to contact the Mental Health Patient Advocate

Anyone with a question or a concern relating to an involuntary patient or someone subject to a CTO may contact the Mental Health Patient Advocate.
“I appreciate the important work your organization carries out for individuals affected by mental illness, their families and caregivers. The Alberta Mental Health Patient Advocate office’s commitment to advocacy, knowledge sharing, and inclusiveness is invaluable in enhancing Albertans’ understanding of mental health issues and available supports. My sincere thank you for your dedication to promoting and protecting the rights of Albertans living with mental illness....”

Government Official

Highlights of the Year

In 2014/15 the Mental Health Patient Advocate assisted roughly six per cent of the 9,802 distinct individuals who received mental health services at inpatient hospitals, certified under the Mental Health Act, and persons under a community treatment order.

As part of the Office of the Alberta Health Advocates, we are located in Edmonton. Most of our work occurs over the phone; however, we visited each of Alberta’s 20 designated mental health facilities during the year and met with 273 individual patients. A summary of activities for 2014/2015 begins on page 19 of this report. Among the highlights:

• A total of 1,421 new files were opened. Those files generated a total of 4,300 issues or requests and 8,352 total contacts.

• Staff conducted 329 investigations into complaints. The investigations found evidence to support 11.6 per cent of the complaints, another 34 per cent were partially supported, and 54.4 per cent were unsupported.

• The top three complaints for the year were: patient rights and responsibilities, treatment and care, and abuse.

• In all, our office provided 149 separate outreach and education services. See pages 26 to 27 for a list of these services.
Thank you so much for your report. This will contribute to our understanding of some patients’ experience….”

Manager, Alberta Health Services

Systemic Advocacy

The Mental Health Patient Advocate participated in systemic advocacy with various organizations. These activities included:

• Providing input to Alberta Health Services on the Suicide Risk Management Policy Suite.

• Continuing work with Alberta Health, Alberta Health Services and other stakeholders to evaluate the implementation and impact of community treatment orders along with the other 2009 and 2010 amendments to the Mental Health Act.

• Partnered in bringing stakeholders together for the Gap Analysis of Public Mental Health and Addictions Forum to improve Albertan’s experience in accessing addiction and mental health services in the Capital region.

• Continuing work on the Provincial Transition Planning Committee mandated to develop approaches to prevent provincial systems from discharging clients into homelessness, pursuant to Strategy 9 of A Plan for Alberta: Ending Homelessness in 10 years. Its scope includes making recommendations for changes to regulations, policies and procedures to implement collaborative planning for provincial systems, and to develop processes for creating coordinated transition planning between systems.

• Continuing work on the Complex Needs Provincial Issue Resolution Committee. It supports the Cross-Ministry Regional Integrated Case Management Teams (RICMT) by addressing and resolving operational, policy, funding or other issues that impede the ability of the RICMT to effectively support adults with complex needs in the community.

• Collaborated with mental health advocates from across Canada to provide feedback to the Mental Health Commission of Canada during its development of Guidelines for Recovery-Oriented Practice. This document helps people to understand recovery and also promotes recovery principles whereby people living with a mental illness are able to live a satisfying, hopeful and meaningful life even if or when there are ongoing limitations caused by mental health issues.

The Canadian Network for Mental Health Rights

The Alberta Mental Health Patient Advocate led the founding of the Canadian Network for Mental Health Rights in collaboration with a doctoral student and the University of Alberta. The network is a community of practice of provincial and territorial representatives from across Canada who are mandated to promote and support the legislated rights and/or voice of people living with a mental illness.

The network held its inaugural meeting on October 6, 2014 by teleconference. While still in its infancy, it is hoped that the network will identify mental health rights issues and trends of mutual interest and promote, enable and facilitate knowledge exchange through leadership, shared learning and best practice.
Symposiums

- Children and Youth with Complex Needs and Access to the Mental Health System
- Taking the Next Steps Together

On October 29, 2014, Alberta Mental Health Patient Advocate Carol Robertson Baker and Alberta Child and Youth Advocate Del Graff co-hosted a symposium entitled “Taking the Next Steps Together” in collaboration with The Alberta Centre for Child, Family and Community Research. Its purpose was to focus on the progress achieved to date to further advance to the preferred state as identified in the work from a symposium we co-hosted on February 19, 2014 entitled “A Policy-Practice Conversation Focusing on Children and Youth with Complex Needs and Access to the Mental Health System.” More than 100 provincial leaders from different sectors and disciplines involved in working with youth with complex needs and young people involved in the system attended both symposiums.

The first symposium resulted in a report entitled The Case for Change: Children and Youth with Complex Needs and Access to the Mental Health System. It included seven recommendations that could be taken collaboratively, and individually, by government and non-government organizations to build a strong mental health system for our province’s young people with complex needs.

The second symposium resulted in a report entitled Taking the Next Steps Together. The report encouraged action to embrace the seven recommendations as the children’s addiction and mental health plan evolves and is implemented, and to publicly report on the progress of the initiatives and outcomes that are achieved for children, youth and families as a result of these efforts.

“Build the system for them, not for us.”
Symposium Participant

“We have a responsibility to work together to ensure that no one is left behind.”
Carol Robertson Baker

The Case for Change: Children and Youth with Complex Needs and Access to the Mental Health System recommendations are as follows:

1: Build a system that helps navigate the mental health system

2: Provide services that put children and youth first

3: Increase Focus and Support for People who Care for Children, Youth and Families

4: Establish Communication that Builds Bridges and Creates a Community

5: Allocate Resources that Better Reflect the Current Situation

6: Measure Progress: Are Children and Youth Getting Better?

7: Build Leadership that Sets the Bar for Mental Health
“The Advocate went beyond my expectations.”

*Formal Patient*

**Monitoring Performance Measures**

The Mental Health Patient Advocate and staff are committed to providing excellent service delivery and being accountable to Albertans for our actions. Below is a list of our performance measures (PM) and our outcomes in 2014/15.

We are proud to say that we significantly exceeded all of our performance measures with the exception of one that pertained to completing informal investigations within five days 90 percent of the time. We met the measure 83 percent of the time in 2014/15 (down from 98% in 2013/14) largely due to insufficient resources and the complexity of the investigations.

83% (PM 90%) of informal investigations were completed within 5 days of the complaint being lodged with the MHPA.

90% (PM 85%) of advocacy inquiries were resolved within 3 days.

97% (PM 85%) of information inquiries about the *Mental Health Act* and its application in practice were resolved within 3 days.

96% (PM 85%) of workshop participants rated the effectiveness of the workshop as “excellent” or “good” in increasing their understanding of client/patient rights under the *Mental Health Act.*
“Thank you for your vision and for the work you do to support Albertans with mental health concerns…”

*Executive Director, Community Agency*

## Core Activities

Core Functions of the Alberta Mental Health Patient Advocate are:

### CARE

#### CONCERNS & COMPLAINTS

Complaint investigation may address a number of issues including the application of the *Mental Health Act*, rights of persons under the Act, administrative fairness, alleged abuse, a failure or refusal to provide services to the individual, terms and conditions under which services are provided to the individual and professional practice and/or unprofessional conduct. Complaints and concerns may be clinical or non-clinical in nature.

#### ADVOCACY

Self-advocacy refers to activities where individuals are coached and supported to act on their own behalf. Individual advocacy occurs when assistance is requested to ensure the client’s voice is heard and considered by the interdisciplinary team. Collective advocacy involves a number of agencies with a common call for change. Systemic advocacy involves strategically improving the system through changes to service delivery, policy and legislation.

#### RIGHTS

Rights information refers to the process by which persons under the jurisdiction of the Mental Health Patient Advocate are informed of their rights. In Alberta, rights information is provided to mental health patients by hospital or community staff or physicians and/or independently by the Mental Health Patient Advocate and staff.

#### EDUCATION

Education includes activities such as the provision of information about the *Mental Health Act*, legislated rights, and the role of patient advocacy in the provision of mental health services. Education is provided to a broad range of stakeholders including service providers, clients and their families, community organizations, professional bodies, lawyers, government ministries, students, the public, and many others.
Complaint

Resolution Process

Under the *Mental Health Act*, persons who are or have been under one or two admission certificates or renewal certificates, or subject to a community treatment order (CTO) or those acting on their behalf, may contact the Mental Health Patient Advocate if they have a concern with the rights, detention, treatment and/or care of the person.

All inquiries made by the Mental Health Patient Advocate into complaints and concerns are called investigations, which may be informal or formal.

Most concerns that are brought to the attention of the Mental Health Patient Advocate can be resolved through informal investigation, conciliation, and mediation. Informal investigations usually involve discussion between the client, an advocate and, often, members of the interdisciplinary team. Only the Mental Health Patient Advocate may authorize a formal investigation. Formal investigations are investigations that cannot be easily resolved over the telephone. They could include complaints about alleged abuse or events that happened many years ago when the person was detained. All information about an investigation is documented in the Office of the Alberta Health Advocates data system and remains confidential as required by law.
“The Advocate was comforting….I felt like the Advocate heard me and I felt validated.”

*Formal Patient*

**Complaint Resolution Process**

A complaint or concern is made with the Mental Health Patient Advocate.

A patient rights advocate determines if the person is or has been under one or two admission or renewal certificates or a community treatment order under the *Mental Health Act*.

A patient rights advocate and the complainant discuss the concerns and develop an action plan.

If the concern does not fall under the Mental Health Patient Advocate’s mandate, the person will be referred.

A patient rights advocate conducts an investigation.
The Mental Health Patient Advocate approves the formal investigation and assigns an advocate to investigate the complaint.

An advocate writes an investigation report which includes findings and recommendations.

MHPA notifies various parties such as the patient, hospital board, health authority, and/or an issuing psychiatrist about the complaint and the investigation as required by law.

A copy of pertinent sections of the patient's health record is obtained in addition to policies, procedures, and other documents related to the complaint.

An advocate interviews the complainant and other involved parties in person, including the patient.

The Mental Health Patient Advocate forwards the investigation report to the Mental Health Patient Advocate for review.

The Mental Health Patient Advocate finalizes the investigation report. The report is sent to the hospital board, health authority, and/or an issuing psychiatrist. The Mental Health Patient Advocate requests a written response to the recommendations and actions taken.

A letter is sent to the patient to inform him or her of the disposition of the complaint.

The Mental Health Patient Advocate receives a response to the recommendations from the hospital board, health authority, and/or an issuing psychiatrist. If the Mental Health Patient Advocate is of the opinion appropriate action was taken, the file is closed. If not, the Mental Health Patient Advocate is required by law to send a copy of the investigation report and the response, if any, to the Minister of Alberta Health.
Informal Investigation

If the complaint was made by someone acting on the patient's behalf, a patient rights advocate contacts the patient to discuss.

If the advocate finds evidence to support a complaint, recommendations are forwarded to the appropriate people.

An advocate contacts the staff, psychiatrist, physician, or whoever is responsible for the patient's treatment and care and/or who is aware of the situation.

An advocate follows up on the recommendations to determine what action was taken.

If the person who filed the complaint and the advocate are satisfied with the resolution, the file is closed. If the person is not satisfied, an advocate may take the matter to a higher level at the hospital or the community health area and/or consult with the Mental Health Patient Advocate. It may result in a formal investigation.

“The service was very good….I will be talking with you again. Thank you.”

Formal Patient
Summary
of Core Activities

A. GENERAL
Four core activities (concerns and complaints, advocacy, rights information and education) of the Mental Health Patient Advocate are summarized in Figure I. The data reflects the combination of client case files, resource service activities, and education files.

Client Case files are opened for persons who fall under the jurisdiction of the Mental Health Patient Advocate currently or in the past (see Sections B and C). Resource Services are files opened for those who request information (see Section D). Education files include presentations and displays (see Section E Education Services).

Figure I Client case files, resource and education services:

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client Case Files</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Files</td>
<td>576</td>
<td>727</td>
</tr>
<tr>
<td>Issues/Requests</td>
<td>3,189</td>
<td>4,585</td>
</tr>
<tr>
<td>Contacts</td>
<td>5,599</td>
<td>7,132</td>
</tr>
<tr>
<td><strong>Resource Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Files</td>
<td>785</td>
<td>1,281</td>
</tr>
<tr>
<td>Issues/Requests</td>
<td>1,111</td>
<td>2,123</td>
</tr>
<tr>
<td>Contacts</td>
<td>2,753</td>
<td>3,581</td>
</tr>
<tr>
<td><strong>Education Files</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Files</td>
<td>60</td>
<td>42</td>
</tr>
<tr>
<td><strong>Overall Core Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Files</td>
<td>1,421</td>
<td>2,050</td>
</tr>
<tr>
<td>Total Issues/Requests</td>
<td>4,300</td>
<td>6,708</td>
</tr>
<tr>
<td>Total Contacts</td>
<td>8,352</td>
<td>10,713</td>
</tr>
</tbody>
</table>

“You guys are doing a great job. I’m thankful you’re here to help us.”

Formal Patient

A total of 1,421 new case files were opened in 2014/15, generating 4,300 issues or requests, which meant a total of 8,352 contacts with individuals.

The MHPA had a significant decrease in the number of client files from 727 files in 2013/14 to 576 in 2014/15. Although we were unable to conduct any formal investigations, we completed 329 informal investigations. The reduction in client files and the inability to conduct formal investigations were largely due to a lack of resources.

The MHPA opened 785 resource files for individuals who contacted us for consultation and to better understand mental health legislation, down from 1,281 files in 2013/14. This was expected as the Health Advocate and the Seniors’ Advocate are now assisting Albertans to navigate the system, among other duties.

There were 60 education files opened, up from 42 in the previous fiscal year.

NOTE: A new file can generate a number of issues, requests, and contacts.
B. CLIENT CASE WORK
According to the Mental Health Act, the first Form 1 admission certificate may be issued anywhere in Alberta, however, formal patients may be accommodated in only 20 designated hospitals across the province. A community treatment order may be issued while the person is still in hospital, about to be discharged, or in the community. While clients may live anywhere in Alberta, the majority of calls received are from patients hospitalized in the communities with the largest number of designated mental health hospitals – Edmonton and Calgary.

Figure II Client Case Files
Total Issues/Requests by type:

<table>
<thead>
<tr>
<th>Client Case Files</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rights</td>
<td>2,611</td>
<td>3,467</td>
</tr>
<tr>
<td>Clinical</td>
<td>243</td>
<td>359</td>
</tr>
<tr>
<td>Administrative</td>
<td>286</td>
<td>682</td>
</tr>
<tr>
<td>Legal *</td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td>Social/Financial</td>
<td>3</td>
<td>31</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,189</strong></td>
<td><strong>4,585</strong></td>
</tr>
</tbody>
</table>

*Legal includes information about court and referral to a lawyer.

The total number of client issues/requests for 2014/15 was 3,189, a 30.4 per cent decrease from 2013/14. Categories are approximate since most cases are complex and presenting issues can be classified in more than one way, depending upon the area of focus. Consistent with previous years, there was a wide range of issues/requests. Most issues/requests reflected an ongoing emphasis on legislated rights and the involuntary apprehension, detention, control and treatment provisions of the MHA.

Advocates helped clients to:

- Resolve complaints
- Understand and exercise their legislated rights
- Ensure their legislated rights were respected
- Learn how to self-advocate
- Ensure the client’s voice was heard and considered when clients were unable to advocate for themselves
- Understand the roles and responsibilities of the various health care providers.
Figure III illustrates the legal status of the clients and the case files opened as a result. The term “other involuntary” refers to clients under compulsory detention in designated mental health facilities by way of the Public Health Act, Disposition Orders from the courts and the Forensic Alberta Review Board.

In 2014/15, 92.9 per cent of the Client Case Files involved formal patients, 3.1 per cent involved persons subject to a single admission certificate, 3.1 per cent involved persons subject to a CTO, and 0.9 per cent involved persons concurrently subject to CTO and formal status.

C. CLIENT PROFILE

Clients who accessed the MHPA services in 2014/2015 were typically between the ages of 25 to 64 years. There were also 18 adolescents under 18 years of age and 70 seniors over 64 years. More males than females accessed our services.

Figure IV Client Profile by Age:

<table>
<thead>
<tr>
<th>Age</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18</td>
<td>18</td>
<td>17</td>
</tr>
<tr>
<td>Ages 18-24</td>
<td>57</td>
<td>105</td>
</tr>
<tr>
<td>Ages 25-50</td>
<td>232</td>
<td>355</td>
</tr>
<tr>
<td>Ages 51-64</td>
<td>133</td>
<td>152</td>
</tr>
<tr>
<td>65 plus</td>
<td>70</td>
<td>85</td>
</tr>
<tr>
<td>Not specified</td>
<td>66</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>576</td>
<td>727</td>
</tr>
</tbody>
</table>

Figure V Client Profile by Gender:

<table>
<thead>
<tr>
<th>Gender</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>308</td>
<td>372</td>
</tr>
<tr>
<td>Female</td>
<td>268</td>
<td>355</td>
</tr>
<tr>
<td>Total</td>
<td>576</td>
<td>727</td>
</tr>
</tbody>
</table>
Overview

Complaint Investigations

Informal Investigations

A total of 329 investigations were initiated, significantly down from 548 investigations in 2013/2014. All investigations were conducted informally due to lack of resources to conduct formal investigations. In addition to the 329 completed investigations, there were 13 investigations initiated, but later discontinued by the Mental Health Patient Advocate or at the complainant’s request. Below lists the complaints investigated informally according to category of the issue.

<table>
<thead>
<tr>
<th>Nature of Complaint</th>
<th># of Investigations 2014/15</th>
<th># of Investigations 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse</td>
<td>23</td>
<td>11</td>
</tr>
<tr>
<td>Accessibility</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Accident/injury</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Accommodation</td>
<td>13</td>
<td>45</td>
</tr>
<tr>
<td>Advocacy</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Care/treatment</td>
<td>121</td>
<td>184</td>
</tr>
<tr>
<td>Communication</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Coordination &amp; continuity of care</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Dietary</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Discharge</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Environment</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Financial</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Health Information Act</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Loss of property</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>Navigating the system</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Non-clinical services</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Patient rights &amp; responsibilities</td>
<td>117</td>
<td>173</td>
</tr>
<tr>
<td>Patient/visitor safety</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Responsiveness</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Staff attitude/courtesy</td>
<td>12</td>
<td>30</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>329</strong></td>
<td><strong>548</strong></td>
</tr>
</tbody>
</table>

“I sure appreciate this. I should have called a long time ago. Things could have been a lot different.”

*Friend of a Patient*

Most investigations are resolved within a few days through conciliation. The outcomes of investigations vary, depending on the nature of the concern, the action required to resolve the matter, and the complainant’s desired outcome. Evidence must also be found to support the complaint. Figure VI outlines the disposition of the 329 investigations.

**Figure VI** Disposition of Concern/Complaint

- 38 (11.6%) Supported
- 112 (34%) Partially Supported
- 179 (54.4%) Unsupported
RESOLVING CONCERNS:

Below are some examples of complaints and actions taken by the service providers as a result of a Mental Health Patient Advocate informal investigation.

COMPLAINT
A patient complained that they have been on the transfer list for a prolonged period of time to go from a locked unit to an open unit due to the unavailability of beds. The patient said that they were unable to receive needed therapy or utilize off-unit privileges on their current unit.

OUTCOME
Recommended to the unit that their policy of no privileges on a locked unit be reviewed for patients awaiting transfer to an open unit. The patient was eventually transferred to an open unit.

COMPLAINT
A complainant reported that a patient was inappropriately restrained while care was being provided.

OUTCOME
The investigation determined that the use of restraint under this circumstance was a deviation in practice due to miscommunication and lack of education/awareness of the staff involved in the incident. An educational session to those involved was provided by trained personnel and protocol was changed to prevent a similar incident from occurring.

COMPLAINT
A complainant reported that a patient was unfairly restricted from exercising their full privileges, as previously ordered by the doctor.

OUTCOME
The doctor was informed of the complaint. Action was taken to ensure the patient received full privileges.
COMPLAINT
A patient reported that they sustained bruising during a restraint.

OUTCOME
The investigation determined that an inappropriate technique was applied during the restraint. The supervisor provided the staff member involved with education on proper restraint techniques.

COMPLAINT
A complainant reported a patient has been waiting in emergency for a bed for a prolonged period of time. The complainant expressed concern that the patient is suicidal and may go on unauthorized leave from the hospital.

OUTCOME
The investigation determined that the patient was in queue with over 20 co-patients waiting for a bed and that it could take over a day to be transferred to a unit. The patient was monitored by hospital staff as a suicide risk.

COMPLAINT
A patient reported that they were not provided with a copy of their certificates for three days after being certified. It was reported that members of the inter-disciplinary team ignored their request for copies of the certificates and for the Form 12 application so that they could exercise their right to apply to the Review Panel to request cancellation of the certificates.

OUTCOME
The investigation determined that there was no documentation or indication that the patient received notification of formal status pursuant to MHA section 14, nor was there evidence that the patient received the Form 12 application. Unit staff provided the requested information and documented it in the patient health record.
COMPLAINT
A patient reported they were not provided with a copy of their community treatment order.

OUTCOME
A copy of the community treatment order was provided to the patient.

COMPLAINT
A patient complained that their doctor issued a Form 1 admission certificate over one week after personally examining the patient.

OUTCOME
The investigation determined that there was non-compliance with the Mental Health Act. As the doctor did not fully understand the requirements for issuance of certificates under the Mental Health Act, education was provided by the MHPA office.

COMPLAINT
A patient complained that they did not want to receive medication but felt they had no choice but to take it.

OUTCOME
The investigation determined that there was non-compliance with the Mental Health Act due to deviation in practice and unawareness of the full requirements to treat patients under the MHA. Education was provided to all involved by the MHPA office.

COMPLAINT
A patient complained that their Review Panel hearing was inappropriately cancelled.

OUTCOME
The investigation determined that due to miscommunication, the hearing was cancelled. The Review Panel hearing was rescheduled.
D. Resource Services

Figure VII describes the breakdown of Resource Services provided to individuals and groups who contacted the Mental Health Patient Advocate for consultation, to address systemic issues, and for education. Examples of rights information provided include information on the Mental Health Act and its application in practice and access to legal counsel. Often these individuals are coached on self-advocacy.

Figure VII Resource Services: Total Issues/Requests by Core Function:

<table>
<thead>
<tr>
<th>Resource Services</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education Services</td>
<td>371</td>
<td>890</td>
</tr>
<tr>
<td>Advocacy Services</td>
<td>567</td>
<td>1,004</td>
</tr>
<tr>
<td>Rights Information Provided</td>
<td>47</td>
<td>37</td>
</tr>
</tbody>
</table>

E. Education Services

The Mental Health Patient Advocate provided 149 outreach and education services including the following presentations, displays, forums and partnerships.

PRESENTATIONS

- Alberta Health Policy in Motion Thought Leaders Forum
- Alberta Health Services
- Alberta Patient Concerns Resolution Network
- Calgary – Varsity Constituency Office Mental Health Forum
- CMHA Edmonton Region
- Excel Society
- Gap Analysis of Public Mental Health and Addiction Programs Forum
- John Dossetor Health Ethics Centre
- MacEwan University, Psychiatric Nursing Program
- MacEwan University, Social Work Program
- National Association of Federal Retirees
- Northern Lakes College
- Office of the Public Guardian and Public Trustee Provincial Conference
- Schizophrenia Society of Alberta, Red Deer and Calgary
- Seniors Advisory Council for Alberta
- Taking the Next Steps Together: Youth Mental Health Symposium
- United Way, Alberta Capital Region
- University of Alberta, Faculty of Rehabilitation Medicine
- University of Calgary, Community Rehabilitation and Disability Studies

“Thank you very much for taking the time to come and speak to our class this evening on Mental Health and Patient Rights and your role as an Advocate. The topic was very enlightening and informative as well as educational.”

MacEwan University Social Work Student
DISPLAYS
• Clara’s Ride
• College of Licensed Practical Nurses of Alberta Conference
• Lift the Silence, World Suicide Awareness Week Resource Fair, The Edmonton Support Network
• Medical Students for Mental Health Awareness (MSMHA) Club, University of Alberta

STRATEGIC PARTNERSHIPS
The MHPA collaborated with the following organizations on outreach, advocacy, quality improvement, and education initiatives:
• Alberta Alliance on Mental Health and Mental Illness
• The Alberta Centre for Child, Family and Community Research
• Alberta Health Services (AHS)
• Alberta Patient Concerns Resolution Network Health Association (Co-Chair of Education Day)
• Canadian Mental Health Association
• Canadian Network for Mental Health Rights
• City of Edmonton and the United Way
• College of Licensed Practical Nurses of Alberta
• Complex Needs Provincial Issue Resolution Committee
• Government of Alberta Advocates Community of Practice (Vice Chair)
• Health Quality Council of Alberta
• MacEwan University, Psychiatric Nursing Program Advisory Committee (committee member)
• Mental Health Commission of Canada
• Office of the Child and Youth Advocate
• Provincial Transition Planning Committee
• Strategic Clinical Network - Addiction and Mental Health Core Committee
• University of Alberta and AHS Nursing Student Project

FORUMS
• Alberta Medical Association Primary Care Summit
• Consensus Development Conference on Improving Mental Health Transitions
• Imagine Forum
• Moving Towards a Just Culture Throughout Alberta’s Health System
• Taking the Next Steps Together
• Gap Analysis of Public Mental Health and Addiction Programs Forum

ARTICLES AND VIDEOS
• Published article in the Alberta College of Licensed Practical Nurses CARE magazine on “Bridging the Gaps in Care”
• AHS Addictions and Mental Health video production on the Office of the Alberta Health Advocates which was released provincially
A Day in the Life of Beverly Slusarchuk, Patient Rights Advocate

This is a composite of actual cases over a period of time. Names have been changed to protect identities.

Bev met with a patient named Trish on a routine visit at a hospital. During their conversation Trish told Bev that she is being detained and treated with medication against her will. She said that she wants to return to work and that there is nothing wrong with her.

Trish went on to say that her doctor is giving her medication “for her head” and doesn’t feel she needs it. Although she refused an injection, she was given it anyways as someone else provided consent for treatment. Bev told Trish she would talk with her nurse and doctor to better understand the care plan. Bev promised Trish she’d meet with her at the end of the day to discuss it further.

Bev met with Trish’s nurse who told her that Trish has formal status under the MHA. She added that Trish was not under a Form 11 Certificate of Incompetence to Make Treatment Decisions. This form is required when a doctor deems a formal patient incompetent to make treatment decisions and consent for treatment is provided by a substitute decision maker. The nurse also said that the patient has a legal guardian under the Adult Guardian and Trusteeship Act and confirmed that Trish received medication on several occasions in spite of Trish’s objection. She added that Trish reluctantly accepted the medication after a nurse reminded her of the guardian’s consent.

Bev met with Trish’s physician who told her that the guardianship order included “health decisions” and that the guardian provided consent. Bev explained to the physician that under the present circumstances, a Form 11 is required under the MHA. The doctor said he was unaware of the requirement and would complete the Form 11 today. He said he would have Trish’s nurse give her a copy of the form and let her know that she could apply to the Review Panel requesting a review of his opinion.

Later that day, Bev met with Trish and told her of what she learned and provided Trish with information on her rights. Trish told Bev she still believes she doesn’t need the medication and that she will apply to the Panel for a review of the Form 11 and for cancellation of the admission certificates. Bev told her of her right to get a lawyer to assist at the hearing and gave her the number for Legal Aid Alberta. She told Trish she would call her at the end of the week to see if she needed further help.

Bev called Trish as promised. Trish told her that she went to the Panel yesterday, and that the medication was suspended until after the hearing. She said that she was disappointed the Form 11 and the certificates were upheld but was thankful for the opportunity to exercise her rights. She told Bev that she plans to take the medication and won’t make further appeals.

Bev informed the unit supervisor of the resolution. At the supervisor’s request, Bev provided a presentation on the MHA to unit staff and management.
A Day in the Life of
Ryan Bielby,
Patient Rights Advocate

This is a composite of actual cases over a period of time. Names have been changed to protect identities.

Jason telephoned Ryan and was very distraught. He told Ryan that he doesn’t need to be in hospital and wants to be discharged to the community. He explained that he’s being held against his will and has been in hospital for many, many months. He said that it’s unfair and that it has contributed to his outbursts with staff and co-patients on the unit, which resulted in seclusion. Ryan told Jason he would follow up with members of the treatment team and get back to him by the end of the week.

Ryan spoke with Jason’s nurse and doctor. He shared Jason’s story and frustration about his prolonged stay and that Jason believes it has contributed to his outbursts on the unit. He stressed that Jason feels he’s ready to live in the community.

Ryan was told that although Jason is ready for discharge, they are unable to find suitable housing for him due to his particular needs.

They agreed that Jason’s outbursts were largely due to his frustrations with being detained. They said that the hospital was doing its best to discharge Jason but that they needed to ensure he had the right community supports in place.

Ryan called Jason and told him that his treatment team agrees he is ready to be discharged. He told him that they are trying to get suitable housing and other supports in place before he’s discharged. Ryan said he would follow up with other key stakeholders to help make this a reality. He encouraged Jason to call him if he has other questions or concerns and to also continue talking with his doctor and nurse. Ryan added that he would call him with any new information.

Ryan called key stakeholders and a meeting was held to discuss the case and find a solution. Suitable housing in the community was identified and work is on-going to get Jason discharged with community supports once a bed becomes available. In the meantime, a community support worker is visiting Jason in hospital several times a week and is taking him on passes.

Jason continues to call Ryan every so often but tells him that things are much better now and that he looks forward to eventually being discharged to a new home.
Consistent Application of the Notification of Rights

Many of the rights of formal patients and persons subject to a community treatment order (CTO) are enshrined in the Mental Health Act (MHA). One of these rights under MHA section 14 is for the “board” to notify the patient and other specific individuals of the certification (detainment), the reasons for the certification, and the right to appeal the certification to the Review Panel. MHA section 48(3) allows for the board to delegate their duties. For persons subject to a CTO and other persons noted in the legislation, the issuing psychiatrist must provide a copy of the CTO and a written statement that includes the reason for issuance of the CTO and the right to appeal to the Review Panel.

Alberta Health Services (AHS) is to be commended for the work they have done to help patients and families, AHS staff, physicians, and the general public become more aware of the MHA and patient rights. They developed and made available a wide range of resources on their website including guides, brochures, checklists, algorithms, and templates for forms to facilitate understanding of the MHA and ensure compliance.

In the vast majority of cases, patients received notification as required under MHA section 14. Some patients have told us, however, that they were unaware of their detainment or being subject to a CTO, were not given copies of their certificates or CTO, and/or were not provided with rights information.

Our investigations into these complaints found evidence to support non-compliance with the MHA in 12 client case files. Through our investigations we determined that some staff were unaware of the notification requirement. For those who were aware of the requirement but did not comply, there was often confusion about who had the duty to provide notification or there was an assumption that it was already provided. Immediate action to ensure compliance did not always occur. While 12 may be seen by some as few, one is one too many for the individual whose rights were not upheld. One must also remember that these were based on complaints to our office. It is unknown if other patients did not receive notification.
AHS’s Patient First Strategy states: “Patients and their families are the centre of everything we do and every decision we make. Albertans have told us they want health care that engages patients and families as full partners in their own care…” It further states that “Patient- and family-centred care sees patients and families as integral members of the health-care team, and encourages their active participation in all aspects of care.” Non-compliance with the MHA by not providing persons subject to the MHA with information on enshrined rights does not reflect patient centred care and is not conducive to building trust between mental health patients, their families, and clinicians.

Patients under the MHA and their families are often in crisis. They may feel scared as they do not understand what is happening to them and angry as they feel they have no control over decisions impacting their life. For some, they may feel confused because this is their first time being hospitalized against their will; they may be wondering why they are being treated like a “criminal” when they have not broken the law. These feelings could be compounded with being acutely ill and perhaps suffering from past trauma. A patient’s experience while under the MHA can be an extremely difficult time in their journey of recovery.

People living with a mental illness must be treated with compassion, dignity and respect. Providing notification to a patient in a caring, clear manner offers the health care provider with a tremendous opportunity to start building a strong therapeutic relationship by spending the time listening and responding to any questions or concerns that the patient or their loved ones may have. It could help them have a more positive experience, even if the patient is being detained. Also, the written notification provided is a helpful reference for patients and for the other individuals who receive it.

It is essential that the rights of all patients subject to the MHA are protected and respected. It is not only the right thing to do, it is the law.

**RECOMMENDATIONS**

I commented on notification of rights in my 2013/14 Annual Report, and yet the issue continues. To uphold patient rights and to ensure compliance with MHA section 14, it is recommended that:

1) the board and/or those delegated pursuant to MHA section 48(3) should have checks and balances in place to ensure compliance, including sporadic audits.

2) incumbents who have been delegated duties of the board should be consistently informed of the delegation, the board’s duties under the MHA, and the policies and procedures that are in place related to these duties.

3) increased accountability and effective, immediate action should occur to ensure compliance when it is determined there is non-compliance. When there are repeated cases of non-compliance on a hospital unit, repercussions should occur.
Treatment
of an Incompetent Formal Patient

A patient is either competent or incompetent to make treatment decisions. If a formal patient is deemed incompetent to make treatment decisions under MHA section 27(1)(2), a physician completes Part 1 of a Form 11 Certificate of Incompetence to Make Treatment Decisions. Part 2 of the Form 11 is completed by the “board.” It provides notification of the certificate and the patient’s right to appeal the physician’s opinion to the Review Panel. Consent for treatment on behalf of the patient may be provided by an alternate or substitute decision maker (SDM) pursuant to MHA section 28. A form 11 is required even if there is a legal guardian.

Respecting and protecting patient rights to informed consent is evident in AHS’s written material. AHS’s website states: “The Consent to Treatment/Procedure(s) Policy supports the rights of patients and families to be informed about the benefits and risks of a proposed treatment or procedure and to make voluntary decisions as to whether to proceed or not.” AHS’s Guide to the Alberta Mental Health Act and Community Treatment Order Legislation (p. 70, 2010) states: “Case law has established that treatment without consent may be negligence or battery. As such, informed consent to treatment must be sought from patients or their substitute decision makers.”

There were several cases where our office determined that a patient received treatment without appropriate consent in place. In one case a formal patient was treated with consent from a SDM prior to the completion of the Form 11 as required by law. Once the MHA requirements were explained, the doctor issued the Form 11. There was another case where the Form 11 was completed but the formal patient was treated without consent from a SDM. Members of the treatment team reported it was not necessary to obtain SDM consent as the incompetent formal patient was complying with treatment. It was explained to them that acquiescence by a formal patient deemed incompetent to make treatment decisions by their doctor is not informed consent. Once the requirements of the MHA were explained, action was taken to provide education to staff and physicians to ensure compliance.

Another issue relating to incompetent patients pertained to their right to request a review of the physician’s opinion regarding competence. We found several cases where patients did not receive a copy of the Form 11 and numerous cases where Part 2, that provides notification and rights information, was not completed. Often staff and managers told us that Part 2 was not completed because they did not know who was responsible to complete it. A Form 11 is a legal document and should be treated that way by fully completing it. Part 2 is one of the provisions under the MHA that protects formal patients. It ensures that patients are properly informed of their rights and the way to exercise those rights.

RECOMMENDATIONS

Similar to the consistent application of notification of certificates, the same three recommendations apply. In this case, however, it is to ensure there is full compliance with the MHA sections 27 and 28.
Physician’s Opinion
Regarding the Issuance and Cancellation of Admission and Renewal Certificates

Revoking an individual’s freedom is often viewed as an extremely serious infringement on their liberties. In order to have formal status, a patient must be under either two Form 1 admission certificates or two Form 2 renewal certificates. It is a physician’s opinion whether or not the patient meets all of the three criteria to issue the certificate. Two physicians must separately be of the opinion that the patient meets all of the three criteria. Once the certificates are issued, the attending physician may cancel the certificates at any time if he or she is of the opinion that the patient no longer meets any one of the three criteria. Formal patients have the enshrined right to apply to the Review Panel for cancellation of their admission or renewal certificates.

It has been brought to our attention by health care providers that occasionally formal patients are not assessed by their physician on an on-going basis to determine if they continue to meet all of the three criteria. This could result in patients needlessly being detained under the MHA until the certificates lapse or are cancelled by the Review Panel. We have also been told that there are a significant number of Review Panel hearings that are cancelled less than 24 hours before the hearing.

It is interesting to note that in 2014/15, of the 1,954 applications to the Review Panel for cancellation of admission or renewal certificates, 1,042 hearings were cancelled. Reasons for cancellation were as follows: the certificates were cancelled (50.8%); the application was withdrawn (38.1%); or for other reasons (11.1%) such as the Chair disallowing the application or the patient was transferred or “awolled”. Out of the 1,042 cancellations, 251 or 24.1% were cancelled less than 24 hours before the hearing.

Physicians have told us that it takes time for the medication to go into effect and that the timing of cancellation of the certificates within 24 hours of the hearing is coincidental. Based on what we have been told by others, however, it would be good practice to monitor the patient more closely to determine if he or she no longer meets any of the three criteria, and if so, the certificates should be cancelled. This would ensure patients are not being needlessly detained under the MHA. It may also help to alleviate some of the pressures for psychiatric beds.

RECOMMENDATIONS:
To ensure the certificates of formal patients are reviewed on a daily basis to determine if the patient continues to meet the three criteria under the MHA, it is recommended that consideration be given to:

1) put checks and balances in place to ensure daily monitoring.
2) formally train physicians on the issuance and cancellation of admission and renewal certificates under the MHA and its application in practice.
Use of Control

Much work is being done provincially, nationally and internationally by way of research and ethical discussions on the use of “control”. Control could include seclusion, physical/mechanical restraint and the administration of medication without the patient’s consent.

MHA section 30 provides the authority “to control the person without the person’s consent to the extent necessary to prevent serious bodily harm to the person or to another person by the minimal use of such force, mechanical means or medication as is reasonable, having regard to the physical and mental condition of the person.” Control is not treatment.

Patients have shared their story about being placed in seclusion. Sometimes they were restrained and given an injection to help them “settle”. From their perspective, the use of control was excessive. Some have told us that although there was an incident, control was applied after they had settled. Others have told us that they were not given an opportunity to have a less intrusive intervention before control was applied.

From the patients’ perspective, control may be viewed as punishment. This especially holds true for patients who are acutely ill, come from a different cultural background, have experience in the correctional system, or have lived through overwhelming life experiences. For those who have experienced past trauma, the use of control could re-traumatize them. Some patients have also told us that it is often a uniformed security officer who provides observation when they are in seclusion. They say that it feels like “jail” except that they would be treated better in jail as they would get daily fresh air and exercise. Fresh air and exercise is not the case for most patients when they are secluded for days or weeks at a time.

It is a clinical decision whether or not to use control unless immediate action is required due to imminent danger. A doctor writes an order for seclusion, restraint or medication as needed. It is often the nurse’s discretion to use control based on the order. When we investigate concerns about the use of control, some respondents have difficulty in describing how control was used to “prevent serious bodily harm.”

A Least Restraints policy and procedure developed by AHS is awaiting approval at the time this report was written. It is hoped that it will provide staff with clearer direction on the use of control.

RECOMMENDATIONS

The use of seclusion and restraint may be necessary at times to prevent “serious bodily harm.” For some patients who have experienced control, and for co-patients who have witnessed it, the use of control may have impacted their journey of recovery. To improve the patient experience and to ensure best practice, it is recommended that:

1) AHS strengthens the philosophy of trauma informed care throughout their programs and services.

2) AHS should continue to train clinicians and security in early intervention and managing aggressive behaviour, specific to those living with a mental illness.

3) AHS should monitor the use of control under MHA section 30 to ensure compliance. For those units and hospitals where there is a higher incidence of the use of control, consideration should be given to initiate a quality improvement project with the goal to ensure the safety and security of all while reducing the use of control.
Conveyance to Non-Designated Facilities

In my 2013/14 Annual Report I commented on the issue of police conveyance of an individual subject to the MHA to a non-designated facility. This issue continues.

When an individual is apprehended and conveyed by the police under the MHA, the police have the authority by law to bring the person to one of the 20 designated mental health facilities across Alberta, as identified in the Mental Health Regulation. Although the Regulation does not set the standards, expectations are that the designated facility has the capacity and clinical expertise to observe, examine, assess, treat, detain and manage any risk these patients may pose. Furthermore, there is the expectation that the designated facility has appropriate policies and procedures in place. It is also expected that if the police bring an individual to the facility, the facility has an obligation to serve that patient.

In rural communities without a designated facility, there continues to be the occasion where an individual is conveyed to the local hospital rather than to a designated facility significantly far away. At the non-designated facility, the person is often examined by a physician who determines if the patient meets the criteria to issue an admission certificate. If issued, the patient is then transported to a designated facility. This could prolong the period of detention and delay the patient’s ability to exercise their right to appeal to the Review Panel should they become a formal patient.

The MHA’s requirement to take the individual to a designated facility is one of the safeguards found in the MHA. The current practice used in some of the rural communities could be seen as unfair and by-passing this safeguard.

**RECOMMENDATIONS:**

Times have changed significantly in mental health since the MHA was enacted in 1990. Resources are limited, especially in rural areas. There needs to be a common sense approach to address the issue of apprehension and conveyance while ensuring appropriate safeguards are in place for patients and compliance with the MHA. It is recommended that:

1) the current state of MHA conveyance by the police to a non-designated facility be reviewed to determine the scope of the issue and the root cause.

2) consideration be given to amend the MHA to align with the current practice and that standards be put in place to ensure non-designated facilities have the capacity and clinical expertise to observe, examine, assess, treat, detain and manage any risk these patients may pose.
Overcapacity and Its Impact on Patients

Over the past year we completed an annual visit with many patients under our jurisdiction at each of the 20 designated facilities. We often observed patients in the emergency department in beds located in the hallway and in an “overcapacity” bedroom that was designed for fewer beds on in-patient units. Sometimes a room designed as a general purpose area was converted to a bedroom.

We have not received many patient complaints about being detained under the MHA in a hallway or in an overcapacity room. When a complaint is received, it usually pertains to patients on transition units as they await suitable placement and supports in the community. Some of these patients or their family have expressed frustration as they feel their lives are in “limbo” and commented on the lack of privacy on crowded hospital units. A number of them are unable to go off the unit on a pass. They have told us that they want to be placed in the community so they can have a “home”, not a hospital bed.

Hospital staff, managers and doctors have expressed grave concern about the lack of a private, therapeutic environment for their patients. Some have told us that they are unable to hire extra staff to care for patients when they are overcapacity. They have also wondered if the use of hallways and “overcapacity bedrooms” has resulted in increased agitation in patients, aggressive behavior, and the use of control. Emergency department staff have expressed concern about the length of time it takes for patients to be transferred to a unit and the impact on patient care.

RECOMMENDATIONS:

The Government of Alberta and Alberta Health Services continue to take steps to address issues surrounding hospital beds for mental health patients and the access and availability of community placements and community-based supports. For the interim, to ensure that overcapacity does not impact patient treatment and care and compliance with the MHA, it is recommended that:

1) A psychiatric liaison staff person be available in all Emergency Departments of designated facilities.

2) Patients who do not have off-unit privileges should be assessed on a daily basis to determine if the patient should be granted a pass, regardless of whether or not the patient is on a locked unit.

3) Patient-nurse ratio on units where overcapacity is the norm should be reviewed to ensure best practice and that the patients’ care needs are met.
Aligning the Alberta Mental Health Act with the Canadian Charter of Rights and Freedoms

The Mental Health Act allows for the apprehension and conveyance of an individual to a facility for examination under one Form 1 admission certificate, a warrant for apprehension (Form 8 or 9), or peace officer’s power (Form 10). Some individuals detained in hospital under these “conveyance documents” for up to 24 hours express concern and are surprised to learn that they can be detained in hospital under Alberta legislation.

There is no provision under the MHA to inform these individuals of their detainment, nor is there any requirement to inform them that they have the right to retain and instruct counsel without delay. The Canadian Charter of Rights and Freedoms section 10 states: “Everyone has the right on arrest or detention (a) to be informed promptly of the reasons therefor; (b) to retain and instruct counsel without delay and to be informed of that right; and (c) to have the validity of the detention determined by way of habeas corpus and to be released if the detention is not lawful.”

According to AHS data, 2,979 distinct individuals under conveyance documents received mental health services at inpatient hospitals in April 1, 2014 to March 31, 2015. Fortunately at many AHS facilities these patients are often informed of their detention and that they may retain legal counsel, but it is not always the case. Furthermore it is not required under the MHA. MHA section 14 (1) (a) and (b) “Duties toward patients” as previously discussed is limited to formal patients.

For persons subject to a CTO, it is unclear if the MHA provides the authority to detain a person following conveyance to hospital under a Form 23 CTO Apprehension Order. Individuals are currently being detained until after examination by two physicians.

RECOMMENDATIONS:

I commented on the need to align the MHA with the Canadian Charter of Rights and Freedoms in my 2013/14 Annual Report. The importance of alignment and the protection of patient rights cannot be overstated. Therefore it is recommended that the MHA be amended to:

1) ensure the rights of all detained persons subject to the MHA are enshrined, including those individuals who are subject to a single Form 1 admission certificate, Form 10, or a Form 8 Warrant or Form 9 Extension of Warrant. This would include notification of the reasons for detention and the right to be informed that they may retain and instruct counsel without delay.

2) clarify if individuals can be detained following conveyance to hospital under a Form 23 CTO Apprehension Order. If there is the authority to detain, these individuals should have the same rights as noted in #1.
Organizational Structure

Photo by Janina Linton
Left to right: Beverly Slusarchuk, Patient Rights Advocate
Carol Robertson Baker, Mental Health Patient Advocate
Ryan Bielby, Patient Rights Advocate
Financial Summary

2014/2015
BUDGET $955,000
EXPENSES $784,763
SURPLUS $170,237 *

2013/2014
BUDGET $955,000
EXPENSES $843,000
SURPLUS $112,000

*The 2013/14 surplus was in keeping with the Government of Alberta's fiscal restraint.
Facilities
Designated for Formal (Involuntary) Patients

NORTH ZONE
Fort McMurray
• Northern Lights Regional Health Centre
Grande Prairie
• Queen Elizabeth II Hospital
St. Paul
• St. Therese-St. Paul Healthcare Centre

EDMONTON ZONE
Edmonton
• Alberta Hospital Edmonton
• Grey Nuns Community Hospital
• Misericordia Community Hospital
• Royal Alexandra Hospital
• University of Alberta Hospital
• Villa Caritas

CENTRAL ZONE
Ponoka
• Centennial Centre for Mental Health and Brain Injury
Red Deer
• Red Deer Regional Hospital Centre

CALGARY ZONE
Calgary
• Alberta Children’s Hospital
• Foothills Medical Centre
• Peter Lougheed Centre
• Rockyview General Hospital
• South Health Campus
• Southern Alberta Forensic Psychiatry Centre

SOUTH ZONE
Lethbridge
• Chinook Regional Hospital
Medicine Hat
• Medicine Hat Regional Hospital
Claresholm
• Claresholm Centre for Mental Health and Addictions
Glossary

Admission Certificate: A Form 1 certificate issued under Mental Health Act section 2 by a physician who personally examines the patient and is of the opinion that the person is

a) suffering from mental disorder
b) likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, and
c) unsuitable for admission to a facility other than as a formal patient.

The completion of one admission certificate provides the legal authority for the individual to be brought to and detained in a designated facility for up to 24 hours from the time the person arrives at the facility. A second admission certificate must be issued within 24 hours of the person’s arrival at the facility by a different physician for further detainment. Two admission certificates are sufficient authority to care for, observe, examine, assess, treat, detain and control the person for one month from the date the second admission certificate is issued.

Advocacy:

Self-Advocacy
Individuals advocate for their own needs and interests and may be supported through education, rights information, and coaching.

Individual Advocacy
Represent the interests of "vulnerable" persons. Another individual or agencies act on behalf of an individual. This form of advocacy may or may not be limited to activities where the individual provides instructions.

Collective Advocacy
Involvement by groups or organizations whereby a collective voice is heard to promote and protect the rights of those it represents by offering support, skill development and a common call for change.

Systemic Advocacy
Focuses on issues that affect a broad segment of a particular population. These initiatives may include strategic efforts to improve administrative structures, funding, service delivery and legislation and policy reforms.

Board: Under MHA section 1(1)(c), "board" means "(i) the board of an approved hospital under the Hospitals Act that is designated in whole or in part as a facility, (ii) a provincial health board under the Regional Health Authorities Act, with respect to a hospital that is under the jurisdiction of such a
board and is designated in whole or in part as a facility, or (iii) if a facility is not a facility referred to elsewhere in this clause, the person in charge of the facility”.

Community Treatment Order (CTO): An order issued by two physicians (one must be a psychiatrist) if the person meets certain criteria and the physicians believe the person would experience recurring relapses and hospitalizations if the person does not receive community treatment or care.

Formal Patient: A patient who is admitted involuntarily and detained in a designated facility under the authority of two admission or two renewal certificates under the MHA.

Mental Disorder: A substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality, or ability to meet ordinary demands of life.

Mental Health Act (MHA): Provides the authority, criteria, procedures, and timelines for the apprehension, detention, admission, and treatment of patients and the criteria and conditions for supportive treatment to persons under a community treatment order.

Patient Centred Care: Health care that establishes a partnership among practitioners, patients and their families (when appropriate) to ensure that decisions respect patients’ wants, needs and preferences and that patients have the information and support they need to make decisions and participate in their own care.

Patient Experience: The sum of all interactions, shaped by an organization’s culture, that influence patient perceptions across the continuum of care. (Beryl Institute)

Recovery: The concept of “recovery” in mental health refers to living a satisfying, hopeful, and contributing life, even when mental health problems and mental illnesses cause ongoing limitations. (Mental Health Commission of Canada)

Renewal Certificate: Two Form 2 renewal certificates can be issued before the expiry of the admission certificates if the person continues to meet the three criteria.

Trauma Informed Care: Is a philosophy and treatment framework that involves understanding, recognizing, and responding to the effects of trauma. It emphasizes physical, psychological and emotional safety for both patients and health care providers, and helps those who have experienced trauma re-establish a sense of control and empowerment.
Contact Information

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Toll-Free: 310.0000
Fax: 780.422.0695
E-mail: Info@mhpa.ab.ca

We are available to assist you during regular office hours, 8:15 a.m. to 4:30 p.m. (closed from 12:00 p.m. to 1:00 p.m.) Monday through Friday. If you telephone after hours, a confidential voicemail is available to take your message.

Visit our website at:
www.albertahealthadvocates.ca
When it comes to mental illness and mental health, let’s not look the other way. Each of us must find some meaningful way to show we care and to make a difference.