



# Psychiatric Patient Advocate Office

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

VIA EMAIL

April 8, 2011

Honourable Sophia Aggelonitis, Minister Responsible for Seniors  
Retirement Homes Project  
Ontario Seniors' Secretariat  
777 Bay Street, 6th floor  
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Dear Minister Aggelonitis,

**RE: Proposed Initial Draft Regulations under the *Retirement Homes Act, 2010***

We are pleased to accept your invitation to comment on the Draft Regulation (the "Regulation") promulgated under the *Retirement Homes Act, 2010*.

For over 25 years, the Psychiatric Patient Advocate Office has offered independent advocacy and rights advice services across Ontario to uphold the legal and civil rights of individuals with mental illness. Last year, we provided rights advice over 25,000 times at nearly every designated mental health hospital and ward in Ontario. Our patient advocates assisted psychiatric in-patients with some 3,500 issues related to quality of care, quality of life, legal rights, and access to justice. There is no comparable rights protection and advocacy organization serving vulnerable in-patients in Ontario.

As experts in serving such vulnerable clients within the health care system, we wish to draw your attention to the following issues arising from the Regulation.

### **Section 13 – Hiring staff and volunteers**

The PPAO cautions that the hiring practices described in the Regulation may indirectly criminalize and discriminate against capable and dedicated employees or volunteers who consume mental health services.

As a matter of policy, police are often called upon as front-line responders when a person requests crisis mental health services. These are non-criminal interactions with police acting under the authority of the *Mental Health Act*. There are no fewer than nine such statutory duties under the *Mental Health Act* triggering police interaction. Although all these interactions are non-criminal in nature, police are obliged to create and keep an occurrence record and feel compelled to disclose them on a vulnerable sector screening. There is currently no binding law in Ontario directing when such information is relevant to a vulnerable sector screening, if ever.

As the proposed Regulation mandates a “vulnerable sector screening” for all potential employees, it must ensure adequate protections for persons who have called upon police in their role as front-line mental health service responders. If these non-criminal interactions are disclosed on a vulnerable sector check, they have the effect of criminalizing a personal health issue which is likely to result discriminatory hiring practices, directly or indirectly.

There is clear support for this position. In April or May of this year, the PPAO expects that the Ontario Association of Chiefs of Police will release a new “Guideline to Mental Health Background Checks for Ontario.” It directs police across Ontario to refrain from disclosing any non-criminal contact with persons under the *Mental Health Act* (or any other informal interaction related to a mental health need) where the interaction was non-criminal in nature. This OACP Guideline was developed with the assistance of the Psychiatric Patient Advocate Office, the Ontario Human Rights Commission, the Information and Privacy Commissioner, and the Police Record Check Coalition. The Guideline is not, however, binding law.

Recommendation: Section 13 of the Regulations should be amended to ensure that an employer’s request for a vulnerable sector screening complies with Ontario’s *Human Rights Code* by preventing discriminatory hiring practices. The Regulation must require any Licensee requesting a vulnerable sector check to specifically opt-out from receiving any information stemming from non-criminal contact with police related to a mental health incident or in their role under the *Mental Health Act*.

Recommendation: Section 13 of the Regulations should expand the professions exempt from vulnerable sector checks to include members of the College of Social Workers and Social Service Workers.

### **Section 23 – Safety standards**

The PPAO applauds the clarity of the Regulation prohibiting the use of restraints by a licensee, and the prohibiting of environmental (confinement), chemical and physical restraint under the *Act*.

Recommendation: For greater clarity, the Regulation should specify that restraints in and of themselves are of no therapeutic value or use and do not constitute a *bona fide* treatment modality.

### **Section 24 – Behaviour management**

The PPAO applauds the clarity of the Regulation describing the creation of a behaviour management plan for residents.

Recommendation: Whenever the “behaviour management techniques or strategies” are applied in practice, this should be documented. The behaviour management plan should then be reviewed regularly by all staff involved in the care of the resident: (1) to determine consistency in approach; (2) to identify systemic or environmental triggers to the behaviour, and how to remove these triggers; (3) to determine the success or failure of the strategies and

techniques, and the need to change them accordingly; (4) as an opportunity to collaborate with the resident and/or their substitute decision maker in updating the behaviour management plan.

### **Sections 30 – 34 – Administration of drugs or other substances**

Sections 30 to 34 of the proposed regulations sets out the requirements would apply if a licensee or staff provide administration of drug to a resident. These sections of the proposed regulations include requirements for: how drugs would have to be administered; a medication management system; and record keeping.

Recommendation: The Regulation should be amended to specifically forbid the use of “covert medication” in any case by making it an offense under the *Act* to provide medication without the explicit knowledge and consent of the resident at each instance. Accordingly, the obligation to record every administration of medication should require the licensee or staff member to certify that the resident was informed of the medication.

### **Sections 44 – 49 – Initial assessment and Full Assessment of Care Needs, Plans of Care and Exceptions**

The PPAO applauds the use of plans of care. As indicated by Coroner’s Inquests such as the Inquest into the Death of Jeffrey James,<sup>1</sup> such plans of care are effective in identifying risks early, anticipating needs before they arise, training staff, and empowering the resident as a member of their care team.

The PPAO cautions that the assessment of “risk of harm to self and to others” must be more rigorously defined in regulation. This broad definition evokes the psychiatric criteria applied under the *Mental Health Act* and which may lead to abuses of this same criteria in the context of a retirement home. This criteria could potentially result in overly-aggressive and unnecessary hospitalization in a mental health facility; encourage care givers to threaten or use such involuntary hospitalization as a way of dealing with “difficult” residents; wrongly characterize or diagnose physical medical needs as psychiatric symptoms; or be exploited by unscrupulous substitute decision makers.

The PPAO also cautions that where a resident transfers to a new retirement home, their existing plan of care may be inappropriate given differences in services and facilities. It would be inappropriate for a receiving facility to adopt an existing plan of care as a matter of administrative efficiency.

Recommendation: The Regulation should more clearly state how to conduct a “risk of harm to self and to others” is conducted, and include provision to ensure that this assessment does not

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<sup>1</sup> Inquest into the Death of Jeffrey James (Coroner’s Courts of Toronto, September 15 – October 10, 2008). A copy of the more than 65 recommendations made by the jury with respect to the use of restraints can be found online: [www.ppa.gov.on.ca/pdfs/sys-inq-jam.pdf](http://www.ppa.gov.on.ca/pdfs/sys-inq-jam.pdf).

result in the unnecessary characterization of care needs as falling under the purview of the *Mental Health Act*.

Recommendation: The Regulation should specify that upon transfer to a new residence, an existing Plan of Care must be updated to account for differences between services, facilities, and care needs.

### **Section 52 – Personal assistance services devices**

While the provisions around the use of personal assistance service devices offer a number of protections, there remains a significant gap in how the use of such devices is documented.

Recommendation: The Regulation should specify mandatory documentation requirements with every use of any restrictive personal assistance services device. The Regulation should also specify mandatory care team review of this documentation to support the least use of such devices and consideration of alternatives.

### **Sections 53 – 54, Restraint by a physical device and drug**

In all respects, it is important to remain mindful that the *Retirement Homes Act* is legislation designed to safeguard the right of residents to live in their home with the same autonomy, dignity and respect as any other homeowner. The resident should have no cause to fear those providing services to them, should have no need to bargain for their autonomy under threat of physical abuse from those providing service, and should remain in control of the services delivered to them.

Introducing regulations which prescribe the kind and use of restraints in retirement homes will make it impossible to respect these guiding principles. It will create a *de facto* form of hospitalization or long-term care provided without adequate procedural or medical safeguards. It will also fundamentally change the relationship between resident and service provider by emphasizing the vulnerability of the resident and place them in a position of subordination.

The common law duty of restraint exists solely as an emergency intervention. This duty dictates that facilities may use “reasonable and proportionate restraint in circumstances where it is necessary for a staff member to meet a duty of care in protecting the patient from imminent harm to themselves, or others” (i.e., co-patients, staff, and visitors).

As drafted, the Regulations seek to codify the use of restraints within a retirement home as something other than an immediate emergency. It is certainly appropriate for the Regulation to oblige a licensee to have adequate provision for the potential use of emergency restraint. It is entirely inappropriate however to combine a doctrine of emergency restraint with consent-based restraint as prescribed in voluntary plans of care,<sup>2</sup> or by codifying the use of restraint as a

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<sup>2</sup> See for example *S.M.T. v. Abouelnasr*, [2008] O.J. No. 1298, which asserts that restraint is of a therapeutic or treatment purpose only insofar as it is necessary to facilitate the administration of drugs (at para. 53): “This is a convenient point to note that counsel for the appellant argues that “restraint” is not included in the definition of

“normalized” or occasional intervention in a retirement home. It creates a Regulation that neither comports nor augments the common law duty to restrain, but in fact replaces that duty with a form of quasi-medical intervention. Such intervention can not be reasonably undertaken within context of a retirement home facility. It demands close compliance of, and monitoring by, medical professionals who are specially trained and have a broad range of services and supports at their disposal. The use of restraint is an extremely dangerous intervention. As demonstrated by the James Inquest,<sup>3</sup> episodes of restraint are difficult to manage even within a leading national medical facility that is fully equipped and properly staffed to deal with emergencies and restraint, which provides third-party clinical review and oversight of the care team, and which makes independent advocacy services available to all in-patients. Even in such facilities, the *Mental Health Act* categorically forbids the use of restraints or detention against voluntary patients within the facility.<sup>4</sup> The *Mental Health Act* also specifies that a person is “placed” in restraints, and not “kept under control.”<sup>5</sup> As prescribed, the *Retirement Homes Act* Regulation presents an idealized picture of restraint as something which can be applied and discontinued neatly and rationally. This is rarely, if ever, the case.

These concerns are greatly heightened when the Regulation authorizes the use of chemical restraint. We note that subsequent to the James Inquest, the Chief Pathologist for Ontario, Dr. Michael Pollanen, published a peer-reviewed academic paper highlighting the dangers of restraint use as a cause of death. His paper finds that the risk of pulmonary thrombo-embolism from restraint use is likely under-reported and that chemical restraint may be an exacerbating factor.<sup>6</sup>

The Regulation also falls short of other guidelines on restraint use. The *Coroner’s Act*, for example, was recently amended to require a mandatory inquest wherever a psychiatric in-patient dies proximate to the use of physical restraint. On a narrow reading, this provision would not protect persons in retirement homes. Furthermore, the Regulation does not come close to satisfying the recommendations of the jury as delivered in the James Inquest to prevent similar deaths in the future. Accordingly, the Regulation will do little to prevent such potential injury or death.

By characterizing the Regulation as a sort of “extension” or “augmentation” of the common law duty of restraint, the Regulation introduces a de facto form of long-term or medical care without satisfactory procedural and oversight mechanisms.

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“treatment” under the *Health Care Consent Act*. I do not accept this submission. [...] it is a necessary implication that a health care professional may have to restrain the person in appropriate circumstances in order to administer non-consensual treatment safely. Thus the use of restraint is something for a health related purpose.”

<sup>3</sup> *Infra* at ft. nt. 1.

<sup>4</sup> *Mental Health Act* s. 14: “Nothing in this Act authorizes a psychiatric facility to detain or to restrain an informal or voluntary patient.”

<sup>5</sup> *Mental Health Act* s. 1(1): ““restrain” means *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.”

<sup>6</sup> Michael S. Pollanen and Brendan C. Dickson, “Fatal thromboembolic disease: A risk in physically restrained psychiatric patients” *Journal of Forensic and Legal Medicine* 16 (2009) 284–286.

Recommendation: The PPAO recommends that the sections of the Regulation prescribing procedures which flow from the “common law duty to restrain” should be removed.

Recommendation: If the Regulation prescribing the “common law duty to restrain” remains, it should at a minimum meet the recommendations of the Coroner’s Jury in the Inquest into the Death of Jeffrey James.

These are our submissions. We would be pleased to discuss any of our recommendations further with you at your request.

Regards,

[Original Signed by]

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Vahe Kehyayan  
Director, Psychiatric Patient Advocate Office