ROXANNE STEWART REFUGEE CASE
UCI: 42358610
SUPPORTING DOCUMENTS (PART 2)
Summaries, Reports, Articles, and Evidence

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Contents…

SYSTEMATIC AND PERSONAL VIOLATIONS OF HUMAN RIGHTS AS A MENTAL HEALTH PATIENT

Contents…

(Continued)

(18) MEDICAL DIAGNOSIS/RECORDS: BUTLER HOSPITAL, MEDICAL ASSOCIATES HOSPITAL

(1) CHARACTER REFERENCE DOCUMENTS FOR REFUGEE CLAIMANT, ROXANNE STEWART

Character Reference Documents for Refugee Claimant, Roxanne Stewart

1) List of Academic Achievements and Community Service Activities

2) Copy of Bachelors of Science Degree from Minnesota State University, Moorhead, Cum Laude

3) Copy of Transcript from Rhode Island School of Design (Graduate Program)

4) Copy of Home Nursing Certificate from St. John's Ambulance Brigade, 2006

5) Copy of Certificate of Baptism from Andrew's Memorial Seventh-Day Adventist Church, 2010

6) Copy of Employment Letter and Summary of Benefits from Sportsmax Limited

7) Copy of Letter of Reference for Ryerson University from former Faculty Advisor and Professor, Dr. Michael Ruth, Minnesota State University Moorhead.

8) Copy of Letter of Reference for Ryerson University from former Production Manager, Mrs. Carla Thomas-Hewitt, The Public Broadcasting Corporation of Jamaica.

List of Academic Achievements and Community Service Activities

Roxanne Melissa Stewart
266 Brock Avenue, Toronto Ontario M6K 2M2
Email: rstewart.micopr@gmail.com, Website: www.roxannejohnsonmedia.com Mobile: 647-671-8081

Bio: Roxanne Johnson is a graduate of Minnesota State University Moorhead, where she received a Bachelor of Science in Graphic Communication, graduating Cum Laude in 2004. She went on to do a year at Rhode Island School of Design's graduate program in digital media on a scholarship. Upon returning to Jamaica in 2005, she had experience working as a video editor and motion graphics producer at BlackSlate Media Group Ltd., became a co-host of the youth forum talk show "Rap Time", worked as a motion graphics producer at the Public Broadcasting Corporation of Jamaica and later went on to be a motion graphic artist at Sportsmax Ltd, where she became a news presenter for daughter channel CEEN TV.

While in Jamaica Roxanne Johnson went on to have experience in drama with the Christian drama group the Eagles, and has also done work as a voice talent for various producers.

Her goal is to continue working in television media where her skills as a writer, researcher, producer and television talent can blossom into creating socially and culturally transforming programing.

Academic History

1992 – 1997	St. Andrew High School 7 CXC Subjects
1997 - 1999	St. Andrew High School GCE 'A' levels – Art, English, Economics
2000 - 2004	B.Sc. (Graphic Communication) – Cum Laude Minnesota State University College Awards: Deans List: Spring 2002 Fall 2002 Spring 2003 Fall 2003 Spring 2004 Academic Award For Student Academic Conference 2003
Sept 2004 – April 2005	Partial Scholarship to Rhode Island School of Design Graduate student - MFA in Digital Media (incomplete) (GPA 3.45)

Independent Academic Activities

- Student Academic Conference Spring 2003:
  Independent research and presentation:

Child Soldiers (Along with website)

- Without the guidance of a tutor, undertook independent study of the course *3D Animation* – Grade achieved – A
- Without the guidance of a tutor, undertook as peer group study of the course *Organic Modeling* – Grade achieved – A

N.B. Both courses referred to above were taken for credit and formed part of the compulsory component of my major.

Community Service

- Formerly a member of The Kiwani's Club of New Kingston
- Conducted workshop in Digital Audio at the Gun-Court Rehabilitation Centre as part of Corner Stone Ministries project
- Former Sunday School Teacher – Swallowfield Chapel (2 years)
- Certified Home Nurse at the St. John's Ambulance Brigade
- Volunteered in YWCA After School Care Programme
- Volunteered – Bustamante Children's Hospital
- Volunteered – Golden Age Home (Vinyard Town) in occupational therapy programme
- Volunteered in Swallowfield Chapel's Prison Ministry
- Assistant Adventist Youth Leader in Andrew's Memorial Seventh Day Adventist Church
- Volunteer in Andrews Memorial SDA Homework Centre Programme

Minnesota State University Moorhead

This is to certify that
The Board of Trustees of the Minnesota State Colleges and Universities of Minnesota upon the recommendation of the Faculty of the

Minnesota State University Moorhead

has conferred upon

Roxanne Melissa Stewart

the degree of

Bachelor of Science

Cum Laude

Given at Moorhead, Minnesota, this fourteenth day of May, 2004.

President of the University

Chair of the Board of Trustees of the
Minnesota State Colleges and Universities

RHODE ISLAND SCHOOL OF DESIGN

Office of The Registrar
Rhode Island School of Design
Two College Street
Providence, Rhode Island 02903

FINAL GRADE REPORT

STUDENT: 0858286 Ms. Roxanne M. Stewart

COURSE SECTION	COURSE TITLE	GRAD	CREDITS	INSTRUCTOR
DM-7102-01	DIGITAL MEDIA GRAD S	W	0.00	T. Rueb
DM-7104-01	LECTURE SERIES SEMIN	W	0.00	N. Wardrip-Fruin
DM-7154-01	INTERACTIVE MULTI-ME	W	0.00	M. Domino
DM-7009-01	EXPERIMENTS IN OPTIC	W	0.00	J. Prince
DM-7151-01	SENSING	W	0.00	M. Pingree
				M. Domino

PRIOR			CURRENT			CUMULATIVE		
ATTEMPTED	COMPLETED	GPA	ATTEMPTED	COMPLETED	GPA	ATTEMPTED	COMPLETED	GPA
18.00	18.00	3.45	0.00	0.00	0.00	18.00	18.00	3.45

Ms. Roxanne M. Stewart
5 Queensway
Kingston 10
Jamaica

SPRING 2005 GRADES

THE ST. JOHN AMBULANCE ASSOCIATION & BRIGADE

JAMAICA

THIS IS TO CERTIFY THAT

ROXANNE STEWART

HAS PASSED

IN HOME NURSING

AT HEADQUARTERS, KINGSTON
ST. JOHN AMBULANCE ASSOCIATION

MAY 8, 2006

Director—Association

Valid for three years from date shown hereon.

Baptismal Vows

1. I believe in God the Father, in His Son Jesus Christ, and in the Holy Spirit.
2. I accept the death of Jesus Christ on Calvary as an atoning sacrifice for my sins, and believe that through faith in His shed blood men are saved from sin and its penalty.
3. I renounce the world and its sinful ways, and have accepted Jesus Christ as my personal Saviour, and believe that God, for Christ's sake, has forgiven my sins and given me a new heart.
4. I accept by faith the righteousness of Christ, recognizing Him as my Intercessor in the heavenly sanctuary, and claim His promise to strengthen me by His indwelling Spirit so that I may receive power to do His will.
5. I believe that the Bible is God's inspired Word, and that it constitutes the only rule of faith and practice for the Christian.
6. Loving the Lord with all my heart, it is my purpose, by the power of the indwelling Christ, to keep God's law of Ten Commandments, including the fourth, which requires the observance of the seventh day of the week as the Sabbath of the Lord.
7. I believe that my body is the temple of the Holy Spirit and that I am to honor God by caring for my body in abstaining from such things as alcoholic beverages, tobacco in all its forms, and from unclean foods.
8. I accept the doctrine of spiritual gifts, and believe that the Spirit of Prophecy is one of the identifying marks of the remnant church.
9. I believe in the soon coming of Jesus as the blessed hope, and it is my settled determination to prepare to meet Him in peace, as well as to help others to get ready for His glorious appearing.
10. I believe in church organization, and it is my purpose to support the church by my tithes and offerings, and by my personal effort and influence.
11. I accept the New Testament teaching of baptism by immersion, and desire to be so baptized as a public expression of my faith in Christ and in His forgiveness of my sins.
12. Knowing and understanding the fundamental Bible principles as taught by the Seventh-day Adventist Church, it is my purpose by the grace of God to order my life in harmony with these principles.
13. I believe that the Seventh-day Adventist Church is the remnant church of Bible prophecy, into which people of every nation, race, class, and language are invited and accepted, and I desire membership in its fellowship.

Name Roxanne Stewart Date 4/09/2010

Address 5 Queensway, Kingston 10

PRINTED BY
OPAC PRINTING SOLUTIONS LTD
132d Maxfield Ave Kingston 10 Jamaica WI
Phone (876) 926-4445 968-0712

Certificate of Baptism

"And Jesus, when he was baptized, went up straightway out of the water: and, lo, the heavens were opened unto him, and he saw the Spirit of God descending like a dove, and lighting uopn him." Mathew 3:16.

In harmony with our Lord's command

ROXANNE STEWART

was baptized at Andrews Memorial SDA Church

on the 4th *day of* SEPTEMBER, 2010

Officiating minister LORENZO KING

of the EAST JAMAICA *Conference*

Received into church fellowship

by the ANDREWS MEMORIAL *Seventh-day*

Adventist church on the 4th *day of* SEPT. 2010

Church clerk Rhona Burgen

ATTACHMENT A

JOB DESCRIPTION

JOB TITLE: **GRAPHIC DESIGNER**

DEPARTMENT: **PRODUCTION**

REPORT TO: **CREATIVE DIRECTOR/EXECUTIVE PRODUCER**

As a Graphic Designer, you should have a working knowledge of preparing and presenting visual artwork for television related materials with a clear appreciation for Non-Linear editing. Under direction, you are expected to produce materials for multimedia and television production as well as web content. This involves providing graphic design and graphic preparation of materials for use in TV broadcasting and on the Web.

A critical function is the ability to apply artistic judgment and skill in creating still or motion graphics by using a variety of graphics tools, techniques and materials. You are also expected to exercise considerable personal artistic creativity in creating electronic graphics for the television medium. Installing and maintaining software and (occasionally) troubleshooting hardware and software problems as it relates to graphics equipment is also a requirement. You are expected to keep current with technological advances in TV and web medium.

You will report to the Executive Producer/Creative Director and will be responsible for:

- Completing requested graphics in a timely manner as per set deadlines for all on-air productions
- Developing artistic and creative solutions for editing and program segments, including but not limited to openings and closings of programmes, promotions, station ID's, green screen effects, bulletin board announcements and general station needs
- Providing requested electronic graphics for all on-air productions
- Actively participating in the creation and design of sets for TV productions
- Contributing ideas and designing high quality artwork within company guidelines
- Assisting with internal as well as Outside Broadcast production workflows; must have operational knowledge and understanding of CatDV
- Work with the Creative Team in maintaining the graphic identity of the channels
- Constantly researching and keeping abreast of new software, technology and innovations within the field

You should possess:

- Certification in Graphic Design or related field
- At least 2 years work experience in a similar field
- Excellent time management skills and deadline oriented
- Exceptional creativity and innovation skills
- The ability to provide feedback, accept feedback and offer ideas
- Strong communication skills
- The ability to work methodically

Schedule: Summary of Benefits

Item 1	GRAPHIC DESIGNER
Item 2	November 23, 2015
Item 3	On a permanent basis after successfully completing your probation.
Item 4	One (1) months
Item 5	1,800,000.00 per annum
Item 6	16 days paid vacation
Other Benefits	
Sick Leave	Ten (10) working days per annum paid
Health Insurance	Sagicor Life Jamaica
Group Life Insurance	Sagicor Life Jamaica
Maternity Leave (if applicable)	Eight (8) weeks paid, four (4) weeks unpaid
Pension	Upon implementation

For SportsMax Ltd.

Calais Hayden
Human Resources Manager

I accept the offer of employment on the terms and conditions set out above.

Name of employee: **Roxanne Stewart**

Signed .....

Date ..... Nov. 20, 2015

Admissions,
Ryerson University,
350 Victoria Street,
Toronto, ON M5B 2K3,
Canada

Letter of Reference for Roxanne Stewart

To Whom It May Concern

Dear Sir/Ma'ame,

I have known Roxanne since her sophomore year at Minnesota State University Moorhead and was her Faculty Advisor and Professor during her course of study in Graphic Communications. Roxanne demonstrated in my classes a natural talent for 3D animation and showed self-discipline and dedication particularly in her independent studies on organic modelling.

During her time at Minnesota State University, she excelled academically and made Dean's List multiple times as well as was given an Academic Award. She achieved this while working two on-campus jobs as an administrative assistant and Campus Security dispatcher. Roxanne was also a presenter at MSUM's original student academic conference.

Roxanne not only grew academically but demonstrated leadership skills as the president of the International Student's Club, during which she also led the club into achieving the coveted Dragon Frost award through their teamwork and participation.

Roxanne also demonstrated her ability to develop and grow in several personal areas as well as academically. I believe she will have much to contribute to the graduate program in Communications and Culture at Ryerson University and hope you find in her the same spirit of diligence and creativity that I saw her display at Minnesota State University Moorhead.

It is without reservation that I recommend Roxanne be accepted to your school to pursue her advanced program of studies. If you require further assistance please feel free to contact me at either my email or cell phone number 313-850-6902.

Sincerely,
Dr. Michael L. Ruth, Emeritus
School of Media Arts and Digital Design
Minnesota State University Moorhead
Moorhead, MN 56563
michael.l.ruth@mnstate.edu
mike.l.ruth@gmail.com

313-850-6902 cell

Mrs. Carla Thomas-Hewitt
Letter of Reference
Production Manager, The Public Broadcasting Corporation of Jamaica
5-9 South Odeon Avenue, Kingston 10, Jamaica
Tel: 1(876)754-7225, Cel: 1(876)412-7482, email: cthomas-hewitt@pbcjamaica.org

To Whom It May Concern,
Admissions,
Ryerson University,
350 Victoria Street,
Toronto, ON M5B 2K3,
Canada

Dear Sir/Ma'ame,

I have known Roxanne since her employment with the Public Broadcasting Corporation of Jamaica in October of 2007 as a motion graphic artist. During her time at PBCJ she delivered excellent work, showcasing her talent in 3D animation, special effects and computer generated imaging. She also showed her creativity in producing musical compositions with various sound editing softwares to use as soundtracks to accompany the motion graphics and animation that she would produce for our various television productions.

In fact, Roxanne in her time at PBCJ was also given the award for Most Creative at our yearly prize giving ceremony in 2008. She was a cheerful worker and enjoyed giving her best.

In 2009, so impressed with her skills in multimedia and motion graphics were we, that we also had Roxanne hold a short in-house course to train any staff that was interested, in 3d animation software and computer generated imaging software. She was a gracious and patient tutor and members of staff came away with new found skills.

I am sure, once given the chance to embark on her graduate studies in Communications and Culture at your institution, she will give her utmost towards her area of research.

I wish Roxanne all the best and hope you find in her the unique skills and creative talents that contributed so greatly to our organization at PBCJamaica.

Sincerely,

Thomas-Hewitt

Mrs. Carla Thomas-Hewitt,
Production Manager

(2) RADIOLOGIST REPORT AND ULTRASOUNDS OF PREGNANCY

ANDREWS MEMORIAL HOSPITAL
27 Hope Road, Kingston 10. Jamaica, W.I.
Tel: (876) 926-7401-2 Fax: (876) 929-3820
Email: amh@cwjamaica.com

RADIOLOGY REPORT

PATIENT'S NAME:	**STEWART: ROXANNE**
GENDER:	**F**
AGE:	**35**
CASE NUMBER:	**98236**
LOCATION:	**OPD**
EXAMINATION NO.:	**US17/106**
REFERRING DOCTOR:	**Dr. Mais**
DATE OF EXAMINATION:	**January 3, 2016**

INDICATION (S): Dizziness and gravid, for dating viability of pregnancy.

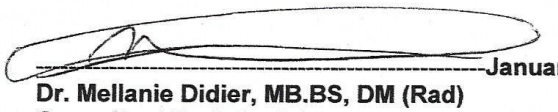
PELVIC ULTRASOUND

Patient gives an LMP of the 26th of November 2016. This corresponds to a gestational age of 5 weeks and 3 days. There is gestational sac seen within the endometrial cavity.
The gestational age via ultrasound parameters corresponds to approximately 5 weeks 0 days using the maximum dimensions. There is a yolk sac seen insitu. A fetal pole is not currently identified.
No subchorionic haemorrhage is demonstrated.
The cervix is long and the internal cervical os is closed.
There is a thick-walled focus within the left ovary with echogenic debris noted within it. There is a suggestion of peripheral vascularity to this focus. The appearances likely represent the corpus luteal cyst.

The right ovary is not clearly identified. No right adnexal masses or collections are seen.
There are pockets of left adnexal and pelvic free fluid. This may be physiological or may represent small amount of leaked fluid from the corpus luteal cyst.
Both kidneys appear unremarkable.

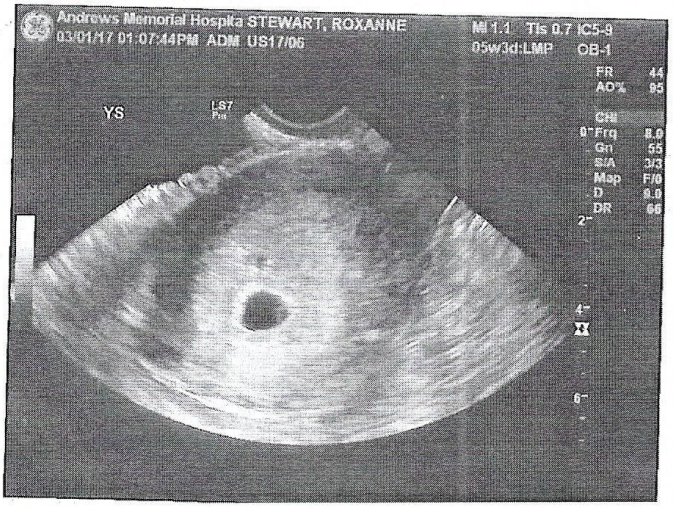
Impression: Gestational sac with a gestational age of approximately 5 weeks 0 day as described. Repeat ultrasound in 14 days may prove useful for continued monitoring of this pregnancy once the patient remains clinically stable.

Thank you for referring your patient to us.



January 3, 2017
Dr. Mellanie Didier, MB.BS, DM (Rad)
Consultant Radiologist

MD/mw


Andrews Memorial Hospita STEWART, ROXANNE
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FR 44
AO% 95
CHI
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Gn 55
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Map F/0
D 8.0
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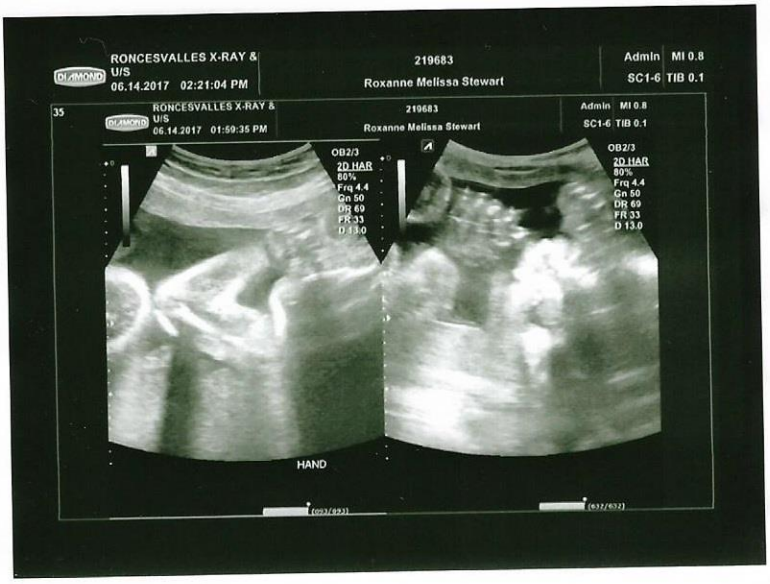
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Gn 50
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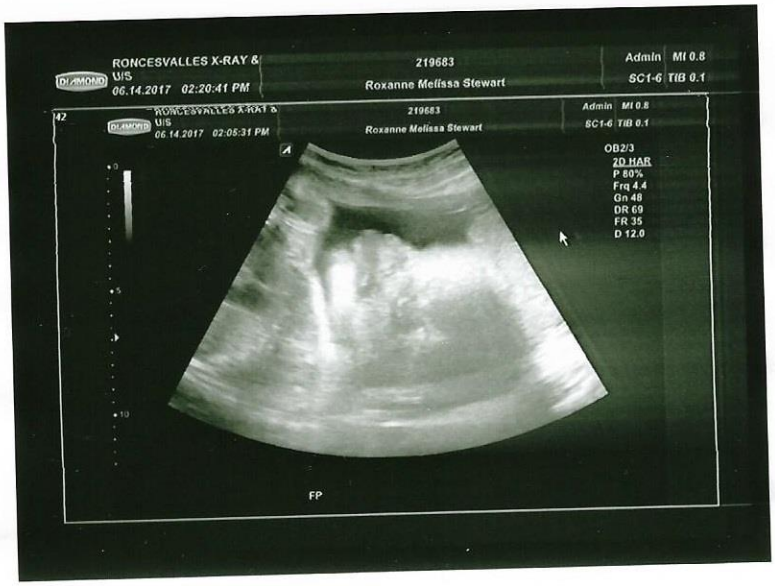
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SC1-6 TIB 0.1
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Roxanne Melissa Stewart
Admin MI 0.8
SC1-6 TIB 0.1
OB2/3
2D HAR
P 80%
Frq 4.4
Gn 48
DR 69
FR 35
D 12.0
FP

(3) STATEMENTS OF ROMAIN JOHNSON'S BEHAVIOR

TO WHOM IT MAY CONCERN

Re Custody of Benjamin Romain Johnson

I Samuel Arturo Stewart of 11a Swallowfield Road, Kingston 5, Jamaica, Attorney-at-law and residing at 5 Queens Way Kingston 10, Jamaica do state as follows:

I am the father of Roxanne Melissa Stewart Johnson, Graphic Communications Consultant, who is the mother of Benjamin Romain Johnson, born on January 14, 2015 to herself and Romain Johnson his father.

From the date of his birth to December 18, 2016 Benjamin and his mother resided at my home with my wife Dr. Marcia Stewart, Roxanne's mother and myself.

During this period, Romain his father would visit from time to time but I am not aware of any monetary contribution made by Romain to the growth, development, medical and pre-school expenses of Benjamin, as my wife Marcia and myself would from time to time assist Roxanne with some of these expenses.

It is a fact that during that period Romain was a student and apparently was not able to contribute meaningfully from his earnings that he gained from part time employment, although I observed that he purchased a couple of toys for Benjamin to play with.

On December 18, 2016 Romain and Roxanne were married at a church in Mandeville, Manchester, Jamaica in a beautiful ceremony with a reception that was held at the Manchester Golf Club attended by family members and friends which Roxanne described as fulfilling her greatest dream.

The couple and their son Benjamin moved into their matrimonial home in a gated community at Oaklands, Constant Spring Road, St. Andrew, Jamaica. However from the end of the first week of the marriage, issues developed which led Roxanne to be concerned about Romain's conduct as on Christmas Day he abandoned his family and went to his parents home by himself after an incident in which he threw Benjamin to the foor.

Subsequently there were a number of other issues which led to disputes between the couple and since January 10, 2017 Romain left the matrimonial home in Oaklands and his job in Kingston, relocated himself to Black River, in St. Elizabeth where he now works and refused to visit or send any financial contribution to assist with the rent, living expenses and maintenance of his son Benjamin or his wife Roxanne, although requested to do so by his wife and reminded by me of his responsibility as a father which he acknowledged, but has not responded with even a token contribution thereto.

In one of the attempts to reconcile their differences Roxanne suggested that they should go to counselling together but he only came to Kingston for one counselling session. Roxanne offered to visit

with him in Black River but he indicated that the accommodation that he had was inadequate and that she should not visit.

Romain's parents who live in rural Jamaica in impoverished conditions do not appear able to assist Romain at this time and in fact they should also be assisted by Romain as they have had to be providing support for his sibblings who are still at school.

Roxanne who had now become emotionally distraught and totally frustrated with Romain, resigned her job and decided to terminate the lease that she had taken out for the matrimonial home and sell the furniture which she had purchased (save and except one television set purchased by Romain which she sold as well and appropriated to his contribution). Roxanne then moved in with her Aunt, Dale Cover and told me that she had specifically invited Romain to visit Benjamin at my home under the supervision of my wife and myself as soon as was convenient.

Roxanne has been the prime caregiver of Benjamin since Romain's departure and she has incurred a considerable amount of debt to do so which was predicated and agreed to be shared by Romain and herself in their marriage. Instead she has had to sell her possessions and be financially assisted by her mother and myself with the hope that she will be able to now recover from the breakdown of the marriage and use her considerable intellectual and artistic talents to earn and income to support herself and her child.

Signed by

Samuel Arturo Stewart

APRIL 5, 2017

In the presence of:

5th APRIL, 2017

SUZANNE RISDEN-FOSTER

Roxanne Stewart-Johnson
Apartment 12a, 3 Grove Park Avenue, Kingston 8,
Cell: 322-1182, Email: rstewart.micopr@gmail.com

A Statement Regarding:
Romain Johnson's Untoward, Abusive and Irresponsible Behaviour Before and During His Marriage to Roxanne Stewart

I, Roxanne Stewart-Johnson, am writing this statement detailing Romain Johnson's untoward, abusive and irresponsible behaviour which demonstrates why I, as his wife, believe he is unfit to be a father to his son Benjamin Johnson or to his unborn child, and why staying in this marriage would be unsafe and precarious for both myself and his children.

Before our marriage Romain has never been able to assist me financially, even while he was working as a pharmacy technician both before and after the birth of his son Benjamin. During our three and a half year relationship before our marriage, it was I and my family who carried the relationship financially.

Early in the year 2013, before our relationship officially begun in May, I had already given Romain $18,000.00 towards classes he had failed and had to retake for his pharmacy program. Due to the fact that Romain was suffering from what appeared to be symptoms of depression, he had much absenteeism during his university undergraduate courses which led him to being a year behind in school. This is what also led to my mother having to pay the tuition fees later for his final year of school before graduating, as the Student Loan Bureaux only finances the number of years a student is supposed to take to finish their program.

It is during the early days of our relationship in 2013 I learned from Romain that during his childhood in Trelawney, he had been the victim of much emotional, verbal and physical abuse at the hands of his parents. He had witnessed his mother being beaten violently by his step father who had broken a glass bottle in her head, and who also had a substance abuse problem particularly with Marijuana, and who's erratic unfaithful behaviour also led to a temporary separation between himself and Romain's mother, during which he threatened to burn down their home with them inside. Romain had also never known his biological father, and admitted to me that his mother, who later confirmed this herself, had only pursued a sexual relationship with his biological father for the purposes of becoming pregnant and having a child. Romain had spoken of incidences of emotional verbal abuse from his mother so severe and traumatic he actually had blocks of time during this period he cannot remember. He also spoke of incidences where his mother beat him with an extension cord as well as a belt. Romain also told me that the relationship between himself and his step-father was very strained to the point where, though his father was responsible for all the cooking in the family, Romain would not eat any meal prepared by his step-father and went through severe weight-loss. It is in the local church that Romain, his mother and his half-siblings sought refuge and comfort. But it is due to knowledge of this abusive and dysfunctional background that I felt it was no wonder that Romain suffered with symptoms of depression and was falling behind in school, and he never received counselling or therapy for the abusive experiences he suffered while living with his family in the country.

During the rest of the year 2013 after our courtship officially began in May, I carried the relationship financially between Romain and myself in our first year of dating, partially living off the approximately 1 million dollars I had earned from a freelance project with E-Learning Jamaica, also having the support of my parents who I lived with at the time. During the entire 3½ year period of our courtship before marriage, in fact, I never pressured Romain for financial support since I felt that as a student and someone coming from an impoverished socio-economic background he would not be able to give me much more than his emotional support and companionship at this time. I felt that when Romain graduated university and became a licenced Pharmacist he would then be more than able to contribute to our relationship financially.

It is also during this time that my family made several contributions to Romain and his family including 3 laptop computers (an Apple, a Hewlett-Packard, and an Acer mini) other computer accessories, and I also sent for his sisters a host of brand new clothing.

Even though Romain made no financial contributions during our first year of courtship, the relationship was a happy one, with what I felt was healthy open communication, affection and emotional support.

After I became pregnant with our son Benjamin in 2014, however, Romain's behaviour began to change. He became emotionally unsupportive, unsympathetic toward my severe morning sickness and we often had many disagreements. Romain also became very controlling, very strict in prohibiting me from having any male friends, even though he had several female friends in pharmacy school and at his part time job. At one point a friendship I had with a friend, Edwin Tulloch-Reid, led Romain to threaten that he would go to Edwin's office and punch him. Even the aspect of going to the hospital because of severe pregnancy related nausea caused arguments between us. A close friend and neighbour I had and would often visit, Mrs. Colette Garrick, also noted to me that Romain had a trust and jealousy problem. My parents attributed Romain's threat to assault my friend Edwin, to immaturity since Romain was 9 years younger than me in age.

Still we continued on in our relationship and Romain, even though working as a pharmacy technician at Liguanea Lane pharmacy, was still unable to make any financial contributions towards my ante-natal care due to his very humble salary, and the hefty bills for obstetrician appointments, ultrasounds, and hospital bill at Andrew's Memorial Hospital for the labour and c-section delivery of our son was entirely paid by my parents, as by this time the money I had earned in my freelance E-Learning Jamaica project had been exhausted, and I also was not working and so had no income.

After our son Benjamin's birth in January of 2015, myself and Romain planned for our future and looked more seriously at our intentions of getting married. By November of that year I had attained a full-time job at Sportsmax Limited as a graphic designer earning about $120,000.00 a month after taxes and was hopeful that my new salaried job, along with Romain soon to be working as a licenced pharmacist would afford us the financial independence that would allow us to get married and live in our own home.

By the time of our 3 year anniversary May 1st, 2016 Roman, myself and my mother discussed an official wedding date of December 18th 2016, which would allow Romain to graduate and take the exam to become a licenced pharmacist before we were married.

Things seemed to temporarily improve in the relationship and I was hopeful that the prospect of living in our own home as a married couple and family, financially independent of my parents would improve Romain's sense of self-worth and improve the relationship. It was also before the wedding in

approximately late November of 2016 that I became pregnant with Romain's second child. It was a pregnancy that was planned for and wanted.

In the months leading up to the wedding I saved most of my salary at Sportsmax, to be used towards paying 6 months rent and security deposit for a home for us to move into once married, and also to put towards wedding preparations. Since Romain was still not a licenced pharmacist and still earning a humble salary as a pharmacist technician, he was still unable to assist financially towards the wedding or towards future living expenses. It was during this time my mother complained he had not even contributed a token amount to the planning of the wedding after she had arranged two separate data-entry jobs in which he would have earned upwards of $50,000.00 each. I, still cognisant of Romain's impoverished family background and the very poor living conditions of his mother, step-father, and half-siblings in Trelawney, defended that since they faced such dire circumstances, Romain should be allowed to send whatever his earnings were to his mother in the country.

It is during the months leading up to the wedding that I also met Romain's uncle Cleavy Baily, his mother's paternal uncle who was dying of a chest infection at Chest Hospital in Kingston. Romain informed me that this uncle, who also had a criminal record for murder, on multiple occasions tried to sexual assault Romain's mother, and this same uncle was also successful in raping his own daughter. Romain's uncle, Cleavy Baily, had also, on multiple occasions, threatened to kill Romain's mother, step-father and siblings and they had had to make police reports about his threatening behaviour for their safety. More of Romain's past as it was revealed to me, explained his emotionally unstable and at times border-line abusive behaviour, and why he seemed to suffer from depression.

Romain also, as I discovered suffered from a severe pornography addiction and had what I thought was a chronic masturbation disorder which seemed to have become worse after our relationship became a sexual one in 2014. Though we had gotten re-baptised in the Adventist church after the birth of our son out of wed-lock, as was the regulation in the Seventh-Day Adventist church for evidence of fornication, he still pressured me for sex and was often disgruntled that I did not gratify him more sexually. This was often the cause of many disagreements. Romain had also made it known to me that as a little boy he had been molested sexually by an older young lady who baby-sat him while he was about six or seven, and I saw that as possibly having some contribution to his perverse addictions and behaviour towards me.

Finally it was after our wedding during our brief period of living together as a married couple that Romain's dysfunctional behaviour became very apparent. He was resentful towards our 23 month old son Benjamin, and though the toddler was sick with a tonsil infection and had fever, Romain would insist that he be left in his crib to cry and not be comforted in the bed with us. Romain became even more controlling and strict, insisting that for Sabbath we not be allowed to buy any food even though there was hardly anything in the house to eat. On one occasion he pretended he was going to burn me with the hot iron he was using to iron his clothes that morning, and finally on December 25th, Christmas day he shoved our son Benjamin by the head into the floor in our living room. From there, things seemed to spiral downhill as he also began to have an inappropriate relationship with a young lady he knew from university called Shanel Menzes. After several attempts to get us counselling from the pastor who married us at our wedding, and an appeal to Romain's mother that Romain needed counselling for what I saw as mental instability, the relationship between himself and Shanel Menzes continued, and as a result I made a video message on January 7th, 2017, detailing the challenges we were having in our

marriage and asking for help which I sent to friends and family through private whatsapp messages and emails. After the video message had made known to our friends and family Romain's abusive behaviours towards myself and Benjamin, it was shortly after this that Romain chose to separate from us and move to Black River, St. Elizabeth where he worked with NHF at the Black River Hospital.

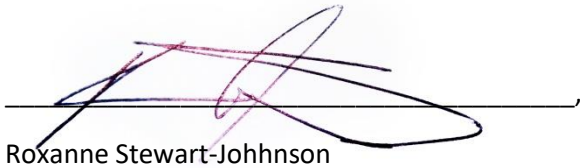
Since leaving for St. Elizabeth, because of the small monthly earnings Romain makes from his employment at Black River hospital, more than half of which goes towards his late fee payments to the Student Loan Bureaux, Romain as per usual, has not been able to make any financial contributions towards his new young family since our marriage. He has not sent any money towards our son, Benjamin's expenses or school fees, towards the rent at our residence in Oaklands, Constant Spring, or any of our utility bills. Romain has also stated that he feels no obligation to provide for us financially or come back to our marriage, even though shortly before our separation I had given him $190,000.00 towards his Student Loan arrears out of my personal savings and a loan I had taken out with COK. I have had to survive financially with the help of my parents and also by selling all of our household appliances and furniture and finally moving back with my aunt who lives in Constant Spring to release us from the $70,000.00 rent we were facing by living in the townhouse in Oaklands.

Romain's mother Mrs. White also became verbally abusive when she called me a slut via a private Whatsapp message, and Romain adamantly defended her behaviour when asked about it. Romain also swore he would not return to our marriage until I felt "every inch of pain" I had caused his mother due to the video message I had sent out to friends and family asking for help.

Romain also became threatening and antagonistic in our phone calls while he was living in St. Elizabeth, and at one time threatened to inject me with Modecate (Fluphenazine), a powerful anti-psychotic and also began pressuring me to have an abortion. I had to block him twice on my phone because he started to insult me, and I generally do not see a marriage with Romain as a safe situation for myself, our son or our unborn child.

I do not believe Romain is emotionally capable at this time of being a loving supportive father to Benjamin, and has proven that he needs some amount of psychological counselling because of his unstable abusive behavior, and the child-abuse of his past and at this time I feel it is unsafe for me to continue as a partner with him in this marriage.

Sincerely,



Roxanne Stewart-Johhnson

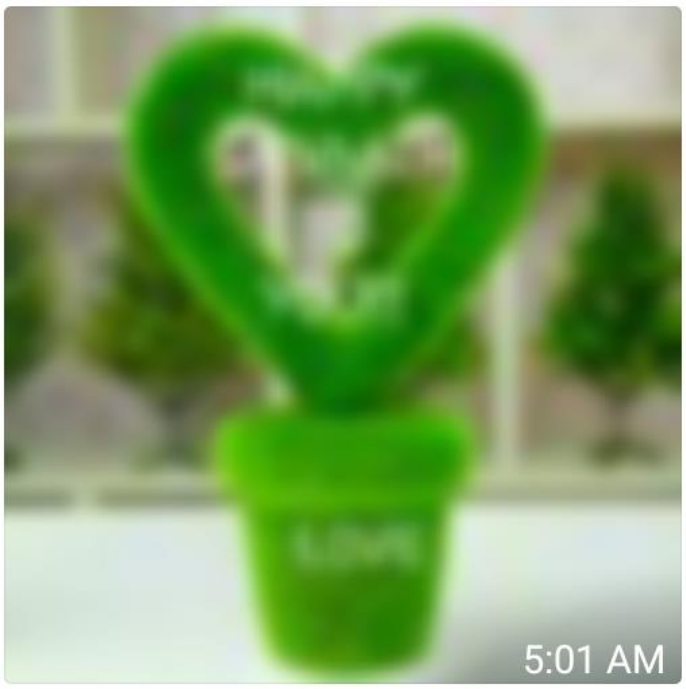
(4) ONLINE HARRASSMENT MADE TOWARDS CLAIMANT, ROXANNE STEWART, BY IMMEDIATE FAMILY OF HUSBAND ROMAIN JOHNSON

95% 8:43 PM

Mrs White
online

on cheeting on me with her, to please not get her pregnant or bring home disease. 10:22 PM

JANUARY 7, 2017



FEBRUARY 4, 2017

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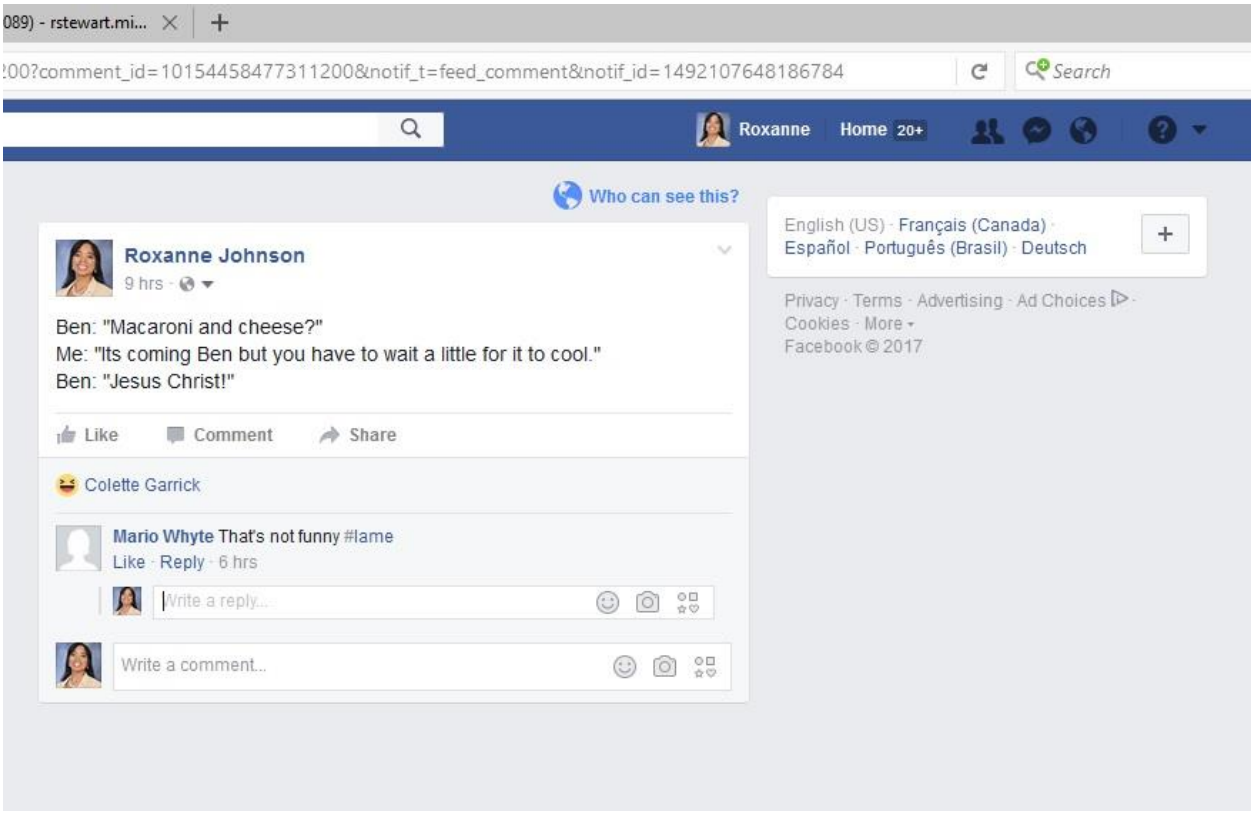
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Roxanne
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Who can see this?
Roxanne Johnson
9 hrs
Ben: "Macaroni and cheese?"
Me: "Its coming Ben but you have to wait a little for it to cool."
Ben: "Jesus Christ!"
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(5) SUMMARY OF PROBLEMATIC ISSUES, LACK OF LEGISLATION AND HUMAN RIGHTS OBSERVATION IN JAMAICA EXPOSING CLAIMANT ROXANNE STEWART, TO SYSTEMATIC AND PERSONAL VIOLATIONS OF HUMAN RIGHTS AS A MENTAL HEALTH PATIENT

Summary of Problematic Issues and Lack of Legislation and Observation of Human Rights in Jamaica that Exposes Claimant, Roxanne Stewart, to Systematic and Personal Violations of Her Human Rights as a Mental Health Patient

1) According to an August 2011 Jamaica Observer article, Dr. Wendel Abel, consultant psychiatrist at the University Hospital of the West Indies reports that Jamaica is in contravention of international treaties the country has signed because of unjustified involuntary hospitalizations where person are locked away and their fundamental human rights taken away.

2) According to a May 2016 RJR News Article Dr. Wendel Abel also reported Jamaica is at risk of breaching human rights treaties for the treatment of the mentally ill. And in the Auditor General's Performance Audit Report on the Health Ministries Management of Mental Health Services, at Bellevue Hospital, more than 80 percent of patients were stable and should have been at home with their families.

3) In a February 2011 Jamaica Observer Article, Carol Narcisse, co-founder of the mental health support group MENSASA reported that all categories of people with mental illnesses' rights were being abused. "Jamaica is in serious breach of the right of the mentally ill to appropriate health and appropriate services based on their disability." Consultant forensic psychiatrist Dr. Clayton Sewel in assessing general conditions also said "The facilities in Jamaica are not in keeping, arguably with the human rights standards to which we have agreed."

4) In a WHO – AIMS 2009 Report on Mental Health System in Jamaica, the executive summary shows that the number of psychiatrists in the country only works out to 1 per every 100,000 persons in a population of 2.7 million. There is also a dearth of psychologists, social workers and occupational therapists in the island due to the unattractive remuneration in the public sector.

5) In a 2012 WHO Assessment of the Pharmaceutical Situation in Jamaica, the report shows Jamaica does not have an officially adopted National Pharmaceutical Policy. (NB: A National Pharmaceuticals Policy is one that aims at ensuring that people get good quality drugs at the lowest possible price, and that doctors prescribe the minimum of required drugs in order to treat the patient's illness.)

Prescribing is mostly done by doctors, but few prescribers have been recently trained in rational use of medicines.

Standard Treatment Guidelines (STG) was available in less than half of public healthcare facilities (46.4%). Not every public health facility had the VEN List, since it was only available in about 1 in each three facilities (35.7%).

(NB: Standard Treatment Guidelines ensure consistency, and treatment efficacy for patients across demographic and geographic barriers.)
The doctor is the most frequent prescriber found; nevertheless, the use of INN in public health facilities was lower than 50% and few prescribers have been recently trained in rational use of medicines.

The training of prescribers related to good prescribing practices, including the use of evidence, prescribing by the International Non-proprietary Name (INN) as well as the improvement of the availability and incentives for the use of the Standard Treatment Guideline (STG) and the Vital, Essential and Necessary (VEN) List are aspects that need to be considered as part of the rational use of medicines strategies.

6) In a December 2016 The Gleaner article, Jamaica minister of Health reported that hospitals lacked transparency and needed to be more accountable.

7) In an October 2016 Jamaica Observer Article, it was shown that the Director of Medical Associates Hospital, (a hospital where claimant Roxanne Stewart received the treatment of Fluphenazine without her consent in 2015) Dr. Michael Banbury had been charged with fraud but released due to the prosecution being abandoned.

8) The sphere of influence of psychiatrist, Dr. Jacqueline Martin (the doctor who threatened claimant, Roxanne Stewart) is also quite powerful as she sits on the board of directors for Medical Associates Hospital, is a consultant psychiatrist for the University Hospital of the West Indies, claims to be a head administrator for Ward 21 of the University Hospital of the West Indies, and is also a lecturer in the Faculty of Medical Sciences at the University of The West Indies, the most prestigious University in the country.

(6) 2012 WHO ASSESSMENT OF PHARMACEUTICAL SITUATION IN JAMAICA

Pharmaceutical Situation in Jamaica

WHO Assessment of Level II - Health Facilities and Household Survey

Technical Series:
Essential Medicines,
Pharmaceutical Policies

Pharmaceutical Situation in Jamaica

WHO Assessment of Level II - Health Facilities and Household Survey

Technical Series: Essential Medicines, Pharmaceutical Policies, Nº 5

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1. Pharmaceutical services
2. Pharmacy administration
3. Health facilities
4. Data collection
5. Americas

(NLM Classification: WA730 DJ2)

Table of Contents

List of figures, tables and boxes

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The data entry, analysis and report editing team included Hank Williams, Tennien Black, Tisannia Tam, Kemoya Stewart and Andrew Bennett.

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Conflict of interest statement

None of the authors of this survey or anyone who participated or collaborated in any phase of the planning, field work, analysis or interpretation of the results had any competing financial or other interests.

Abbreviations and acronyms

ACP	African, Caribbean and Pacific
ARI	Acute respiratory infection
bd	*Bis die* (Latin for "twice a day")
CIA	Central Intelligence Agency (of the United States of America)
CRDTL	Caribbean Regional Drug Test Laboratory
DHI	Development Human Index
DTCs	Drugs and Therapeutics Committees
EML	Essential Medicines List
EU	European Union
GDP	Gross domestic product
HCL	Health Corporation Limited
HFS	Health Facility Survey
IMCI	Integrated management of childhood illness
INN	International Non-proprietary Name
J$	Jamaican dollar
JADEP	Jamaica Drugs for the Elderly Program
mg	Milligrams
ml	Milliliter
MOH	Ministry of Health
NAF/ENSP/Fiocruz	Center for Pharmaceutical Policies/Sérgio Arouca National School of Public Health/Oswaldo Cruz Foundation (Núcleo de Assistência Farmacêutica/Escola Nacional de Saúde Pública Sérgio Arouca/ Fundação Oswaldo Cruz)
NGO	Non-governmental organizations
NHF	National Health Fund
NMP	National Medicines Policy

NPP	National Pharmaceutical Policy
ORS	Oral rehydration salts
PAHO	Pan American Health Organization
PIOJ	Planning Institute of Jamaica
RDU	Rational drug use
RHA	Regional Health Authority
RUM	Rational use of medicine
SES	Socioeconomic Status
SF	Survey Formulary
STATIN	Statistical Institute of Jamaica
STG	Standard Treatment Guidelines
STI	Sexually transmitted disease
tab	Tablet
td	Twice daily
UNDP	United Nation Development Program
UNICEF	United Nations Children's Fund
URTI	Upper respiratory tract infection
US$	United States dollar
UTECH	University of Technology
UWI	University of the West Indies
UTI	Urinary tract infection
VEN List	Vital, Essential and Necessary List
WHO	World Health Organization

Foreword

In consonance with Ministry of Health's mandate of "Ensuring the provision of quality health services and to promote healthy lifestyles and environmental practices," I am honoured to present the results of the Pharmaceutical Situation Assessment in Jamaica. The publication report was developed with the technical and financial support from the collaboration of the Pan-American Health Organization/World Health Organization (PAHO/WHO), through the EU/WHO ACP Project "Partnership on Pharmaceutical Policies" and The Centre for Pharmaceutical Policies of the Oswaldo Cruz Foundation in Brazil, PAHO/WHO Collaborating Centre on Pharmaceutical Policies.

The publication report reflects the efforts of the Ministry to provide to the Jamaican citizens medicines of ensured quality and safety and to promote their rational use. The gaps identified are an important resource to inform the development of the National Pharmaceutical Policy. Importantly, it will facilitate the efforts of the Ministry of Health, its Agencies and related organizations, to continue improving the quality of care across the island.

Hon. Dr. Fenton Ferguson
Minister of Health

Executive summary

Country background - Health and pharmaceutical sector

The island of Jamaica lies about 885 km south of Miami, 145 km south of Cuba and 161 km west of Haiti and is located almost at the centre of the Caribbean Sea. It is the largest of the English-speaking Commonwealth Caribbean Islands, and the third-largest island in the region covering an area of 10,999 km^2. The island is divided into three counties and subdivided into 14 parishes.

The population of Jamaica in the year 2006 was 2,673,816. The population growth rate was 0.5% and the total fertility rate was 2.5% and females represented 50.7% of the population. The crude birth rate was 17.04 per 1,000 of population. Infant mortality rate was 19.99 deaths per 1,000 live births. Life expectancy at birth was 73.12 years and 32.5% of the population was below the age of 15 years. The average population density was estimated at 660 per square miles and 48% of the population lived in the rural areas.

Healthcare in Jamaica is provided by the Ministry of Health (MOH), the private sector and other non-governmental organizations. The health system offers primary, secondary, and tertiary care services. Approximately 38% of the population utilizes the public sector for ambulatory care, 57% use the private sector, and 5% use both sectors. Private hospitals only handle about 5% of total hospital services. Public hospitals handle the most complicated and costly cases.

The Standards and Regulation Division of the Ministry of Health (MOH), administers the Food and Drug Act of 1964, and Regulations of 1975, and thus provides the authorization for manufacturing, importation, distribution and use of pharmaceuticals. The Division ensures that all substances used as food, drugs, and cosmetics are efficacious, safe and of high quality. **Jamaica does not have an officially adopted National Pharmaceutical Policy.** There is a draft for submission to Parliament.

(NB: A National Pharmaceuticals Policy is one that aims at ensuring that people get good quality drugs at the lowest possible price, and that doctors prescribe the minimum of required drugs in order to treat the patient's illness.)

The first national essential medicines list—Vital, Essential, and Necessary (VEN) List of medicines—developed to guide the procurement and rational use of pharmaceuticals was published in 1988. It has undergone several subsequent reviews, on an average biannual basis and the last review was in December 2008. This document embraces the concept of rational drug use and serves as a guide to doctors, nurses, pharmacists, and students of these disciplines in the public health sector. The VEN List assists the maintenance of rational prescribing practices in public facilities. The third edition of the National Drug Formulary was issued in 1997.

Health Corporation Limited (HCL), a quasi-private company established in 1994 to ensure the efficient, cost-effective procurement and distribution of pharmaceuticals and medical supplies, has met approximately 70% of the essential needs of the public sector. In 2010, the HCL was merged with the National Health Fund (NHF). The public expenditure on medicines (2006/07) was 680,094,000 Jamaican

dollars (J$) (US$ 7,654,406.30), representing J$ 254.35 (US$ 2.86) per capita. In 2007, there were 516 pharmacies [117 public (83 in operation), and 399 private], 9 private manufacturers and 23 medicines distributors (1 public and 22 private).

Study

The assessment of the pharmaceutical situation, Level II, was undertaken in Jamaica from July, 2009 to May, 2010 using a standardized methodology developed by the World Health Organization (WHO). The goal of the assessment was to evaluate the pharmaceutical situation in Jamaica using outcome indicators. More specifically, the study collected information on access, affordability and availability of key medicines and geographical accessibility of dispensing facilities and **rational use of quality medicines, as well as some data on the quality of medicines at health facilities and pharmacies.** All this information was then used to evaluate whether the goals set for the pharmaceutical sector are being achieved.

The study has two components, both indicators based: health facilities and households survey. In the first approach, data related to the pharmaceutical policy outcome was collected from public healthcare facilities, public and private pharmacies and the public warehouse that supply public facilities. In the second, data came from a survey conducted at household level.

Health facility survey

Methods

The survey was conducted in five areas: North Eastern Region, South East Region – A, South East Region – B, Southern Region and Western Region. In each survey area, 5 to 6 public health care facilities and 2 to 6 private pharmacies were surveyed. In the country 1 public warehouse was surveyed.

In each facility surveyed, a set of survey forms (Annex 2) was applied. The survey commenced following ethical approval from the Ministry of Health's Ethics Committee. Local health managers were contacted for specific local approval and cooperation. The country was divided into five survey areas with a team of workers for each one. Field teams comprised 19 data collectors each (pharmacy interns), selected according to the region to which they were assigned for rotation; and 5 supervisors (regional or senior pharmacists) who oversaw data collection and verified the quality of the data collected. Data collection methods included patient and health worker interviews after oral consent, check list guided observation and clinical and administrative documents review. Data collection took place between January 25 and March 19, 2010.

Data entry was performed using designed summary forms. Analysis was done using Excel® program.

Key results

Access

Overall access indicators show that key essential medicines are largely available in public health facilities (93.3%), warehouses that supply the public health system (100%) and private pharmacies (93.3%). The average length of stock-out duration in public health facilities was 23.1 days, whereas in the warehouse it was only 8.1 days, which indicate that this picture is not stable along time. Due to good availability, most prescribed medicines (76.7%) were found as dispensed in the cross sectional approach.

Concerning geographical accessibility, few of the patients interviewed at public dispensing facilities and private pharmacies have to travel more than one hour to reach the facility.

In treating common conditions [hypertension, diabetes, urinary tract infection (UTI), worm infestation] using standard regimens, the lowest paid government worker would need between 0.1 (diabetes) and 0.8 (hypertension)[1] days' wages to purchase lowest priced generic medicines from the private sector. In the private sector, once originator brands are chosen, costs are higher and the number of days' wages necessary to purchase treatment vary from 0.4 (worm infestation) to 5.2 (hypertension). In the public sector, the medicines are provided free of charge for all conditions chosen.

Data suggests that affordability of treatment for common primary health problems is a large problem when the medication is not available in the public facility, since the burden for the lowest paid public servant in terms of working days is high for common diseases like hypertension.

Quality and regulation

Ten percent of the public dispensaries had expired medicines. Storage conditions varied from 70% of adequacy in the storerooms of public health facilities to 90% of adequacy in warehouses supplying the public sector.

Most of the private pharmacies comply with the law that requires the presence of the pharmacist. On the other hand, only 65% of public dispensaries had a pharmacist present at the time of the visit. Though the profile of most of the health workers dispensing medicines was adequate, a minority of untrained staff was found in both private (11.5%) and public sector (10.3%) facilities. **Prescribing is mostly done by doctors, but few prescribers have been recently trained in rational use of medicines.**

Use of medicines

Antibiotics were prescribed to one in every three patients (33%), and injections to one in every 12 (8%). The use of International Non-proprietary Name (INN) in public health facilities was limited to only 41.9% of the prescription medicines. **Standard Treatment Guidelines (STG) was available in less than half of public healthcare facilities (46.4%). Not every public health facility had the VEN List, since it was only available in about 1 in each three facilities (35.7%).**

(NB: Standard Treatment Guidelines ensure consistency, and treatment efficacy for patients across demographic and geographic barriers.)

The selling of prescribed medicines without prescription does not seem to be a widespread practice. Most patients know how to take their medicines in the private pharmacies (90%), while in the public dispensaries that percentage is somewhat lower (73.3%).

[1] . Lowest daily government salary = J$ 642.86 = US$ 7.24 (US$ 1.00 = J$ 88.85).

Challenges and constraints

Most of the private pharmacies comply with the legal provisions set by the government, since pharmacists were found in most of them and the profile of health workers dispensing medicines was adequate. On the other hand, 35% of public dispensaries had no pharmacist at the time of the visit. **The doctor is the most frequent prescriber found; nevertheless, the use of INN in public health facilities was lower than 50% and few prescribers have been recently trained in rational use of medicines.**

In Jamaica, there is a high availability of medicines; nevertheless, the stock-out is still a problem to be faced. The storage conditions were, except in the warehouses, not adequate enough for the public health facilities and private pharmacies.

Although it is more likely to have a pharmacist dispensing in private pharmacies (96.2%) than in public pharmacies (65.5%), untrained staff are equally likely to be found in private pharmacies and public dispensaries (around one in ten dispensers in both cases).

The training of prescribers related to good prescribing practices, including the use of evidence, prescribing by the International Non-proprietary Name (INN) as well as the improvement of the availability and incentives for the use of the Standard Treatment Guideline (STG) and the Vital, Essential and Necessary (VEN) List are aspects that need to be considered as part of the rational use of medicines strategies.

The results of the survey showed high availability of medicines; however, affordability could be a concern for those citizens who would have to source their medication in private sector. The result also shows that managerial and economic policies concerning pharmaceuticals should be improved.

Household survey

Methods

The survey was conducted Jamaica in five survey areas: North-East, South East - A, South East - B, Southern and Western. Households were selected by intentional cluster sampling within defined distances from a reference public health care facility. The reference public health care facilities were selected among those participating in the Level II Facility Survey that was run in parallel. A total of 805 household respondents were interviewed by means of a structured questionnaire made up of 43 questions. Information about medicines kept at home, used during recent acute illness and prescribed for chronic diseases were collected. Data was also collected on behaviours of people confronted with acute or chronic conditions, their opinions about medicines, as well as on the demographic and socioeconomic situation of interviewed households. Data entry was performed with EpiData software and data analysis was conducted using Microsoft Excel®.

Key results

Characteristics of surveyed households

Respondents were selected to be the most knowledgeable persons about matters related to the health of household members. The majority of respondents were between 25 and 50 years old (6 in 10) had completed primary, secondary or high school (8 in 10). Around fifty percent of households spent up to J$ 26,000 (US$ 293) in total per household over 4 weeks.

About one third of households had incurred health expenditures over the past four weeks and around half of households reported at least one recent acute or one chronic condition. The most frequent symptoms of acute illness were related to cough, runny nose, sore throat or ear-ache. The most frequently reported chronic diseases were by far hypertension and diabetes.

Geographic access and availability of medicines

Overall, indicators of geographic access to medicines suggest that the majority of surveyed households live close to a public health care facility. Nevertheless, the majority of medicines, either found in households or obtained for an acute illness, came from a private pharmacy.

Nine in ten household respondents agreed that medicines are available at private pharmacies, while only one-third of household respondents agreed that medicines are at their public health care facility.

Affordability of medicines

Overall, indicators of affordability of medicines suggest that the price households pay for medicines in the private sector is an obstacle to accessing medicines, since 26% of people with chronic conditions reported not taking prescribed medicines because they could not afford the treatment. For acute conditions, the percentage of people not taking medicines because of financial reasons is 11%. For those who paid for medicines, the average cost of a prescription for acute illness was J$ 2,969 (US$ 33), with a maximum of J$ 100,000 (US$ 1,125). The average monthly cost of medicines for chronic diseases was J$ 1,900 (US$ 21), with a maximum of J$ 100,000 (US$ 1,125).

One quarter of people with acute health conditions reported having health insurance coverage for medicines. About half of the medicines used to treat chronic conditions were covered by health insurance.

Medicine use and medicines at home

About 69% of the households with children kept medicines at home. The average number of medicines found at home was 2.7. About three quarters of these medicines had an appropriate label, validity and a primary package in good condition, especially when obtained from private pharmacies.

Medicine use and acute illnesses

Almost 8 in 10 persons with an illness perceived to be very serious sought care and took prescribed medicines. The most common prescribers were doctors. The use of injections for acute illness was very low. The main reason given for not taking medicines was not following prescription.

Medicine use and chronic diseases

The number of people with chronic disease told to take medicines and who did not take them was 20%. The main reason given for not taking medicines was not following the prescription.

Opinions about quality of care and generics

Overall, half of respondents (52%) believed that the quality of services in their public health care facility was good and 41% of respondents did not know whether brand name medicines are better than generic medicines.

Challenges and constraints

Despite the high geographical accessibility and perception of availability of medicines in the public health facilities, as well as found in the HFS, the affordability with high private expenditure on medicines is a challenge to be faced, as 26% of people with chronic conditions and 11% of people with acute conditions reported not taking prescribed medicines because they could not afford the treatment.

The perception of households related to the quality of the service in the public services and the quality of generics needs to be improved. The same applies to the need for adherence to the treatment of chronic conditions.

Recommendations

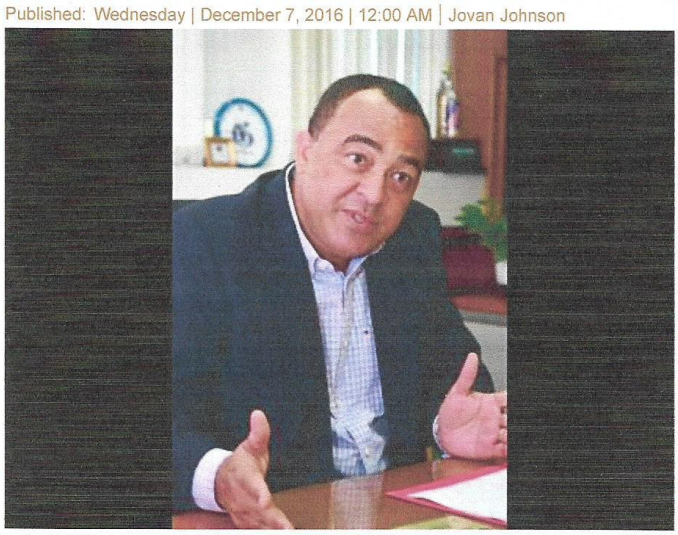
The development and official adoption of a National Pharmaceutical Policy is highly recommended to address the main challenges and constraints identified in the surveys. Affordability and price of medicines seems to be priority issues to be addressed. **Another priority area is the quality assurance of products and services in the medicines distribution at the central medical store and dispensing facilities such as pharmacies, with the development of Good Practices.**

Additionally, strategies for promoting the rational use of medicines, such as updating the VEN List based on the concept of Essential Medicines, the updating and strengthen of adherence to Therapeutic Formulary and STG as well as the promotion of Good Prescription Practices and the use of INN for prescribing and rational use of medicines for the public are very necessary.

(7) DECEMBER 2016 GLEANER ARTICLE: “Hospital Needs to Be More Accountable – Tufton”

Hospital Heads Need To Be More Accountable - Tufton

Published: Wednesday | December 7, 2016 | 12:00 AM | Jovan Johnson



Dr Christopher Tufton during an interview with The Gleaner. Patrick Planter

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By about March next year, the Government should have a better look at how it will be able to strengthen the management and accountability of health institutions such as hospitals under a 10-year plan for the health sector, Health Minister Dr Christopher Tufton has said.

Tufton complained in an interview with **The Gleaner** recently that the current structures, which were established through the National Health Services Act 1997, need to be reformed to ensure that those directly in charge of health institutions are more empowered to do their jobs while also being held more accountable.

The National Health Services Act, which established regional boards that oversee hospitals and other institutions, is among the things being reviewed to develop a 10-year strategic plan aimed at enhancing Jamaica's public-health system.

A report, Tufton said, should come before him by the first quarter of 2017.

"I'm hoping to have some sort of preliminary positions, early new year - the first quarter of next year - but we're not waiting on that to do some of the things that need to be done," he said.

The review will lead to the 10-year plan that was initiated last year. After mounting public pressure, the then administration released audits of public hospitals, which pointed to a widespread lack of basic supplies, usage of expired ones, and a general breakdown of controls and management in various institutions.

The public clamoured in vain for people to be held accountable for the failures.

PROCESS NEEDS RETHINKING

Tufton suggested that the current management structures could be shielding those with direct supervision over institutions.

"You have a regional structure that, oftentimes, is the ultimate authority to determine and oversee the functioning of the institutions, which is the hospitals and clinics. I would like us, with the experts, to rethink that process.

"We took the regional structure from the British. It was expected to be reviewed in three years. It has not been to date. The British have gone through several variations of their regional approach. In Canada, Toronto proper has three million people with one authority. We have three million people and we have four [regional authorities]," said Tufton.

According to the health minister, "To get greater value, [the answer] must be to and accountability to the institutional leadership.

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"Each hospital has a chief executive officer (CEO) and senior medical officer (SMO), and then under that, you have differing levels. To my mind, a CEO and SMO who are given the task to run a facility must understand their budget targets, performance target, and must be held accountable. There is a disconnect between management and authority," Tufton told **The Gleaner**.

He said the National Health Services Act does not give the permanent secretary the power to intervene in questionable situations. That, he said, has partly influenced how the Andrew Holness-led administration is approaching the situation.

"From this administration's perspective, we have said the institutions have to take more responsibility. When there's a an issue, if you notice under my watch, I don't jump to the front of the line to start justifying or explaining things. If there's an issue, the first point of contact must be the SMO and the CEO of that institution because, frankly, they are responsible for that institution and should be accountable."

The Inter-American Development Bank and the World Bank are helping with the work on the 10-year strategic plan.

jovan.johnson@gleanerjm.com

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Man Thing • 6 months ago

You are so right Minister the current structure is a waste of taxpayers money a eat a food mentality structure we the public needs more accountability, performance and management pay them more reasonable too we can't have growth with a defective health sector

1 ^ v • Share ›

Angelena • 6 months ago

Jesus Lord !!!!
I knew it would come to this. When they can't fulfill and manage their portfolio, they throw it on the poor, underpaid, overworked staff.

Especially this one, always taking up what he can't manage.

^ v • Share ›

Barb Walt • 6 months ago

That is so right. These in charge people must get daily reports of what a gwaan in the the institution, good or bad so that things can get fixed before it reach the crisis mode. A very BIG problem is the pacenter of which staff work. People in outpatient wait all day for the very minimal service. They need to communicate with the pharmacy to know if the drug they order is available before they send the patient to the pharmacy to wait half the day only to be told the drug not available and to come back tomorrow. That has happened to my poor weak uncle several times. He have to find taxi money each time. These heads of the institution must make impromptu rounds to get a grip on how the people suffa fi get some treatment. I have multiple examples. It have to get better Sir Minister!!!!!

^ v • Share ›

hypersan • 6 months ago

Brilliant

^ v • Share ›

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(8) CODE OF PROFESSIONAL ETHICS FOR PHYSICIANS AS LAID OUT BY THE MEDICAL ASSOCIATION OF JAMAICA

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Headline

Code of Professional Ethics for Physicians

Code of Professional Ethics for Physicians

The medical practioner has responsibilities to: the patient, the society, other health professionals as well as to him/herself.

The concerns most often highlighted are: the patient and physician relationship, the conduct and practice of the physician, conflicts of interest, professional relations and societal responsibilities.

All codes of conduct are built on ethical foundations. In this case:

1. Patient-physician Relationship

a. Beneficence . . . the welfare of the patient is central.
b. Non-malfeasance – "primum non nocerce" (first do not harm).
c. Autonomy – respect for right of patients to make choices.
d. Justice – avoidance of discrimination on the basis of rule, colour, religion or national origin.

2. Physicians' Conduct and Practice

a. Veracity. Always tell the truth. Do not ever represent yourself in any communications that could be considered untruthful, misleading or deceptive.
b. Maintain medical competence
i. Study ii. Application iii. Enhance skill
c. Behaviour must not diminish capability to practice optimally. Questionable conduct or unethical behaviour will be investigated.

3. Conflicts of Interest require public disclosure

Our most important role is that of patient advocates. Physicians are obligated to recognize conflicts of interest and deal with them through public disclosures.

The patient interest is paramount. Autonomy of patient is fundamental.

If not resolved, withdraw from patient care. Do no commercial promotion of medical products and services that will generate bias, create or appear to create undue influence. All treatment offered must be based solely on medical considerations and patients' needs.

Ethics

Gifts of substantial value from health care companies demand disclosure.

4. Professional Relationship
Respect and cooperate with:
· Other physicians
· Nurses
· Other Health Care Professionals

Patients must be aware of the financial requirements of their care before treatment.

Other healthcare professionals must reflect fairness, honesty, integrity, mutual respect and concerns for patients.

To provide the best care for the patient, consult, refer and cooperate with others as

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necessary.

It is incumbent on you to report to the appropriate authority, unethical or illegal behaviour by impaired physicians.

5. Societal Responsibilities
All physicians are required to uphold the dignity and honour of the profession. They must contribute to:
· Societal enhancement
· The support for and participation in all public concerns for the advancement of the human family.
· Ensure the respect for the laws that govern society.

6. Patient-Physician Relationship
· The central focus of all ethical concerns.
· The welfare of the patient IS the basis of all medical judgements.
· As patient advocate, physicians must exercise all reasonable means to ensure appropriate care.
· Relationships are built on: trust, confidentiality, honesty.
· The physician may only refuse to give care if there is no physician/patient relationship, except in emergencies.

· Either patient or physician is free to discontinue relationship but physician should first establish alternate continuing care.

7. Sexual misconduct is an abuse of professional power and a violation of patient trust.
8. A romantic relationship between physician and patient is unethical.
9. Informed consent
a) Obligation to informed consent includes knowledge that Terms are understandable.

Pertinent medical facts and recommendations must be consistent with good medical care.

b) Alternate modes to be presented.
c) Objectives, risks, benefits, possible complications and anticipated results are to be discussed

It is unethical to prescribe, provide or seek compensation FOR THERAPIES OF NO BENEFIT TO THE PATIENT.

10. Always respect the rights of patients and colleagues.
11. Patient confidences: the patient must give consent for the information to be divulged.

PHYSICIAN CONDUCT & PRACTICE

1. All medics must recognize the boundaries of their expertise and provide only those for which they are qualified by education, training and experience.

2. Participate in continuing medical education to enhance knowledge and competence.

3. Protect patient welfare in new emerging therapies.

4. Never publicize or represent yourself in an untruthful, misleading or deceptive manner to patients, public or other health care professionals.

5. The HIV Positive physician should inform all patients.

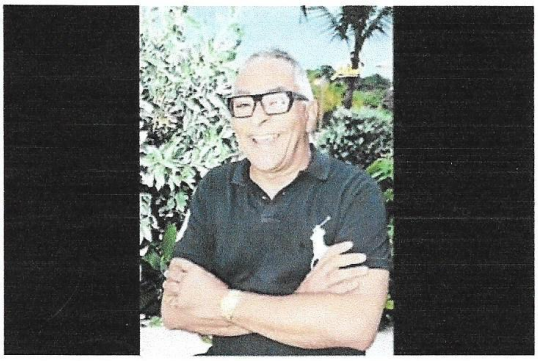
6. The impaired physician, with alcohol, drugs, mental, emotional or physical disability, should not practice medicine until the impairment no longer affects the quality of patient care.

Be guided by the "golden rule". Pay attention to standards, objectivity, competence and the science of medicine.

(9) OCTOBER 2016 JAMAICA OBSERVER ARTICLE:
“Dr. On Fraud Charges Freed”

Doctor on fraud charges freed

Friday, October 07, 2016 9 Comments



KINGSTON, Jamaica – Director of Medical Associates hospital in St Andrew Dr Michael Banbury was today freed of fraud charges in the Kingston and St Andrew Parish Court after the prosecution entered a nolle prosequi.

Prosecutor Taneshia Evans Bibbon told Senior Parish Judge Judith Pusey that the Director of Public Prosecution has ruled that the matter should be adjourned at this time as the Crown is unable to sustain the case against the doctor.

Nonetheless, Evans Bobbin indicated that further investigation will be carried out to substantiate the Crown's case, raising the possibility that it is brought back to court.

The 60-year-old doctor was arrested and charged in February with forgery, uttering forged document and conspiracy to defraud.

It is alleged that a forged shares transfer instrument was used to transfer a little over 404,000 shares from a company called Community Medical Service to the hospital.

Tanesha Mundle

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Free Jamaica • 8 months ago
Why was the case brought to the courts if there was a nolle prosequi. Surely they would know that in the first place.
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Original Foxylady ↗ Free Jamaica • 8 months ago
Plz read the article again, nolle prosequi simply means the CT is not prosecuting the man AT THIS TIME - he can be brought back in CT on same charges.
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Jas • 8 months ago
Right colour Wrong Country!
2 • Reply • Share ›

Jangas ↗ Jas • 8 months ago
What yu saying? 'Brown-man' get away easy in Jamaica? Wouldn't doubt that one bit.
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Robert Foster • 8 months ago
Wow! It's simply a matter of comparing signatures on the transfer document with those of the original shareholders. Was it signed by the original shareholders or NOT? ...Whats so difficult about that?
2 • Reply • Share ›

Dhc • 8 months ago
Put the man on front page news and charge him for fraud. Then can't prove it. The police and prosecution should be sued. But is normal behavior for them
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Derrick Hennie • 8 months ago
The prosecution must do their homework, before submitting a case, or face a possibility of a countersunk of massive proportion, wrongful arrest, defamation of character, slander, emotional distress, depression and more.
I await the next move, by whomever.
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Duke Prepre • 8 months ago
So, prosecutor Baboon does mot have a case.
1 • Reply • Share ›

Jangas • 8 months ago
Seems that the only cases that can be tied-down and slam-dunked, are ones involving J$100 slices of cheese. Anything bigger than that, and prosecutors 'tun-fool'😉. Jamaica is a trip😄!
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(10) BACKGROUND ON SPHERE OF INFLUENCE OF PSYCHIATRIST DR. JACQUELINE MARTIN

Background on Sphere of Influence on Psychiatrist, Dr. Jacqueline Martin

Dr. Jacqueline Simone Martin is a consultant psychiatrist at the University of the West Indies. She claims to also be a head administrator for Ward 21. She lectures in the Faculty of Medical Sciences at the University of the West Indies and also sits on the Board of Directors of Medical Associates Hospital.

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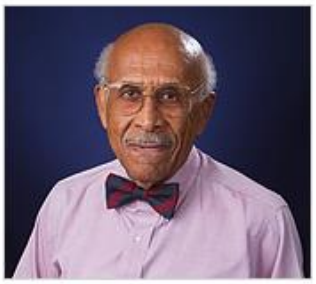

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Dr. Leo Paul Powell

Dr. Nicholas Suite

Mr. Misir

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(11) SUMMARY OF ONTARIO LEGISLATION, RIGHTS AND ORGANIZATIONS THAT WOULD SAFEGUARD AND PROTECT CLAIMANT, ROXANNE STEWART, FROM SIMILAR HUMAN RIGHTS VIOLATIONS EXPERIENCED IN JAMAICA

Summary of Ontario Legislation, Rights and Organizations that would Safeguard and Protect Claimant Roxanne Stewart from Similar Human Rights Violations Experienced in Jamaica

1) According to the Health Care Consent Act of Ontario:

Capacity

4. (1) A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. 1996, c. 2, Sched. A, s. 4 (1).

Wishes

5. (1) A person may, while capable, express wishes with respect to treatment, admission to a care facility or a personal assistance service. 1996, c. 2, Sched. A, s. 5 (1).

CONSENT TO TREATMENT

No treatment without consent

10. (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

- **(a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or**
- **(b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1).**

Elements of consent

11. (1) The following are the elements required for consent to treatment:

1. **The consent must relate to the treatment.**
2. **The consent must be informed.**
3. **The consent must be given voluntarily.**
4. **The consent must not be obtained through misrepresentation or fraud. 1996, c. 2, Sched. A, s. 11 (1).**

Informed consent

(2) A consent to treatment is informed if, before giving it,

(a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and

(b) the person received responses to his or her requests for additional information about those matters. 1996, c. 2, Sched. A, s. 11 (2).

Treatment must not begin

18. (1) This section applies if,

(a) a health practitioner proposes a treatment for a person and finds that the person is incapable with respect to the treatment;

(b) before the treatment is begun, the health practitioner is informed that the person intends to apply, or has applied, to the Board for a review of the finding; and

(c) the application to the Board is not prohibited by subsection 32 (2). 1996, c. 2, Sched. A, s. 18 (1).

---

2) According to the Mental Health Act of Ontario:

Effect of Act on rights and privileges

6. Nothing in this Act shall be deemed to affect the rights or privileges of any person except as specifically set out in this Act. R.S.O. 1990, c. M.7, s. 6.

Conditions for involuntary admission

(1.1) The attending physician shall complete a certificate of involuntary admission, a certificate of renewal or a certificate of continuation if, after examining the patient, he or she is of the opinion that the patient,

(a) has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person;

(b) has shown clinical improvement as a result of the treatment;

(c) is suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

(d) given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment;

(e) has been found incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained; and

(f) is not suitable for admission or continuation as an informal or voluntary patient. 2000, c. 9, s. 7 (2); 2015, c. 36, s. 1.

Conditions for involuntary admission

(5) The attending physician shall complete a certificate of involuntary admission, a certificate of renewal or a certificate of continuation if, after examining the patient, he or she is of the opinion both,

(a) that the patient is suffering from mental disorder of a nature or quality that likely will result in,

(i) serious bodily harm to the patient,

(ii) serious bodily harm to another person, or

(iii) serious physical impairment of the patient,

unless the patient remains in the custody of a psychiatric facility; and

(b) that the patient is not suitable for admission or continuation as an informal or voluntary patient. R.S.O. 1990, c. M.7, s. 20 (5); 2000, c. 9, s. 7 (3, 4); 2015, c. 36, s. 1.

---

3) According to The Centre for Addiction and Mental Health Bill of Client Rights:

The Bill of Client Rights has been developed to assert and promote the dignity and worth of all of the people who use the services of the Centre for Addiction and Mental Health (CAMH). The Bill of Client Rights expresses the truth that clients are first and foremost human beings with the same rights as every Canadian.

Every client has the right to be provided with a written copy of, and assistance in understanding the Bill of Client Rights, and to have it posted at CAMH's main entrances and wherever clients receive services.

Right #1

Right to be Treated with Respect Every client:

1) is a person first, and has the right to be treated with respect.

2) has the right to be treated in a respectful manner, regardless of her/his race, culture, colour, religion, sex, age, mental or physical disability, class/economic position, sexual orientation, gender identity, diagnosis, inpatient status, or legal status.
3) has the right to have her/his privacy respected.

4) has the right to respect of her/his needs, wishes, values, beliefs and experience.

Right #2

Right to Freedom from Harm

Every client:
1) has the right not to be coerced or detained except where permitted by law.

2) has the right to be free from locked seclusion, environmental, chemical and mechanical restraint except where permitted by law. (i.e. when a client is a danger to self or others). Only the minimum necessary amount of restraint or locked seclusion is allowed and only after alternative methods of

resolution have been unsuccessful. Clients have the right to be informed of how they can be released from restraints or seclusion.

Right #3

Right to Dignity and Independence
Every client:

1) has the right to have services provided in a manner that respects the dignity, independence and self-determination of the individual.
2) has the right to confidentiality about personal information and records in accordance with the law.

Right #4

Right to Quality Services that Comply with Standards

Every client:

1) has the right to have services provided in a manner that complies with legal, professional, ethical, and other relevant standards.
2) has the right to a choice of services, and will not be denied other options if the client does not choose one treatment or service.
3) has a right to choose the least restrictive care.

4) has the right to have services provided in a manner that minimizes potential harm, and optimizes quality of life.

has the right to seek an additional medical opinion.

Right #6

Right to be Fully Informed

Every client:

1) has the right to be informed of her/his rights in this Bill of Client Rights

Right #7

Right to Make an Informed Choice, and Give Informed Consent to Treatment

1) No treatment shall be given without the client's informed consent, except in accordance with the law.

2) Consent must be for that particular treatment or plan of treatment.

3) Consent can be withdrawn at any time.

4) Every client is presumed to have decision-making capacity unless found to be incapable.

5) Consent must be voluntary and not obtained by coercion or misrepresentation.

Every client:

6) has the right to have her/his prior capable wishes respected to the fullest extent that the law allows.

7) has the right to be fully involved in treatment decisions (including location, duration and type of treatment).

Right #10

Right to Complain Every client:

1) has the right to make a complaint, access advocacy and to make suggestions and inquiries.

2) has the right to inform the Empowerment Council or Family Council of her/his complaint(s), in order to seek changes in the system.

Organizations:

1) The CAMH Empowerment Council:

The Empowerment Council is a voice for clients/survivors and ex-clients of mental health and addiction services, primarily of CAMH.

2) The Canadian Mental Health Association:

The Canadian Mental Health Association promotes the mental health of all and supports the resilience and recovery of people experiencing mental illness.

3) The Mental Health Rights Coalition:

The Mental Health Rights Coalition of Hamilton is a non-profit organization funded by Ontario's Ministry of Health and Long Term Care as a Consumer/Survivor Initiative.

The Mental Health Rights Coalition advocates for its members through speaking up at various committees, attempting to create change through the system. This is different from individual advocacy in that we do not take on individual complaints; we use collective complaints as a catalyst for change.

(12) ONTARIO HEALTH CARE CONSENT ACT

Français

Health Care Consent Act, 1996

S.O. 1996, CHAPTER 2
Schedule A

Consolidation Period: From January 1, 2017 to the e-Laws currency date.

Last amendment: 2016, c. 23, s. 51.

Legislative History: 1998, c. 26, s. 104; 2000, c. 9, s. 31-48; 2002, c. 18, Sched. A, s. 10; 2004, c. 3, Sched. A, s. 84; 2006, c. 19, Sched. L, s. 2; 2006, c. 21, Sched. C, s. 111; 2006, c. 26, s. 14; 2006, c. 34, s. 34; 2006, c. 35, Sched. C, s. 52; 2007, c. 8, s. 207; 2007, c. 10, Sched. O, s. 13; 2007, c. 10, Sched. P, s. 15; 2007, c. 10, Sched. Q, s. 13; 2007, c. 10, Sched. R, s. 14; 2009, c. 26, s. 10; 2009, c. 33, Sched. 18, s. 10; 2010, c. 1, Sched. 9; 2015, c. 36, s. 17; 2016, c. 23, s. 51.

CONTENTS

PART I
GENERAL

Purposes

1. The purposes of this Act are,

(a) to provide rules with respect to consent to treatment that apply consistently in all settings;

(b) to facilitate treatment, admission to care facilities, and personal assistance services, for persons lacking the capacity to make decisions about such matters;

(c) to enhance the autonomy of persons for whom treatment is proposed, persons for whom admission to a care facility is proposed and persons who are to receive personal assistance services by,

(i) allowing those who have been found to be incapable to apply to a tribunal for a review of the finding,

(ii) allowing incapable persons to request that a representative of their choice be appointed by the tribunal for the purpose of making decisions on their behalf concerning treatment, admission to a care facility or personal assistance services, and

(iii) requiring that wishes with respect to treatment, admission to a care facility or personal assistance services, expressed by persons while capable and after attaining 16 years of age, be adhered to;

(d) to promote communication and understanding between health practitioners and their patients or clients;

(e) to ensure a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment, admission to a care facility or a personal assistance service; and

(f) to permit intervention by the Public Guardian and Trustee only as a last resort in decisions on behalf of incapable persons concerning treatment, admission to a care facility or personal assistance services. 1996, c. 2, Sched. A, s. 1.

Interpretation

2. (1) In this Act,

"attorney for personal care" means an attorney under a power of attorney for personal care given under the *Substitute Decisions Act, 1992*; ("procureur au soin de la personne")

"Board" means the Consent and Capacity Board; ("Commission")

"capable" means mentally capable, and "capacity" has a corresponding meaning; ("capable", "capacité")

"care facility" means,

(a) a long-term care home as defined in the *Long-Term Care Homes Act, 2007*, or

(b) a facility prescribed by the regulations as a care facility; ("établissement de soins")

"community treatment plan" has the same meaning as in the *Mental Health Act*; ("plan de traitement en milieu communautaire")

"course of treatment" means a series or sequence of similar treatments administered to a person over a period of time for a particular health problem; ("série de traitements")

"evaluator" means, in the circumstances prescribed by the regulations,

(a) a member of the College of Audiologists and Speech-Language Pathologists of Ontario,

(b) a member of the College of Dietitians of Ontario,

(c) a member of the College of Nurses of Ontario,

(d) a member of the College of Occupational Therapists of Ontario,

(e) a member of the College of Physicians and Surgeons of Ontario,

(f) a member of the College of Physiotherapists of Ontario,

(g) a member of the College of Psychologists of Ontario, or

(h) a member of a category of persons prescribed by the regulations as evaluators; ("appréciateur")

"guardian of the person" means a guardian of the person appointed under the *Substitute Decisions Act, 1992*; ("tuteur à la personne")

"health practitioner" means a member of a College under the *Regulated Health Professions Act, 1991* or a member of a category of persons prescribed by the regulations as health practitioners; ("praticien de la santé")

"hospital" means a private hospital as defined in the *Private Hospitals Act* or a hospital as defined in the *Public Hospitals Act*; ("hôpital")

"incapable" means mentally incapable, and "incapacity" has a corresponding meaning; ("incapable", "incapacité")

"mental disorder" has the same meaning as in the *Mental Health Act*; ("trouble mental")

"personal assistance service" means assistance with or supervision of hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, positioning or any other routine activity of living, and includes a group of personal assistance services or a plan setting out personal assistance services to be provided to a person, but does not include anything prescribed by the regulations as not constituting a personal assistance service; ("service d'aide personnelle")

"plan of treatment" means a plan that,

(a) is developed by one or more health practitioners,

(b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and

(c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition; ("plan de traitement")

"psychiatric facility" has the same meaning as in the *Mental Health Act*; ("établissement psychiatrique")

"recipient" means a person who is to be provided with one or more personal assistance services,

(a) in a long-term care home as defined in the *Long-Term Care Homes Act, 2007*,

(b) in a place prescribed by the regulations in the circumstances prescribed by the regulations,

(c) under a program prescribed by the regulations in the circumstances prescribed by the regulations, or

(d) by a provider prescribed by the regulations in the circumstances prescribed by the regulations; ("bénéficiaire")

"regulations" means the regulations made under this Act; ("règlements")

"treatment" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan, but does not include,

(a) the assessment for the purpose of this Act of a person's capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the *Substitute Decisions Act, 1992* of a person's capacity to manage property or a person's capacity for personal care, or the assessment of a person's capacity for any other purpose,

(b) the assessment or examination of a person to determine the general nature of the person's condition,

(c) the taking of a person's health history,

(d) the communication of an assessment or diagnosis,

(e) the admission of a person to a hospital or other facility,

(f) a personal assistance service,

(g) a treatment that in the circumstances poses little or no risk of harm to the person,

(h) anything prescribed by the regulations as not constituting treatment. ("traitement") 1996, c. 2, Sched. A, s. 2 (1); 2000, c. 9, s. 31; 2007, c. 8, s. 207 (1); 2009, c. 26, ss. 10 (1, 2); 2009, c. 33, Sched. 18, s. 10 (1).

Refusal of consent

(2) A reference in this Act to refusal of consent includes withdrawal of consent. 1996, c. 2, Sched. A, s. 2 (2).

Section Amendments with date in force (d/m/y)

2000, c. 9, s. 31 - 1/12/2000

2007, c. 8, s. 207 (1) - 1/07/2010; 2007, c. 10, Sched. O, s. 13 - no effect - see 2009, c. 26, s. 10 (1) - 15/12/2009; 2007, c. 10, Sched. P, s. 15 - no effect - see 2009, c. 26, s. 10 (1) - 15/12/2009; 2007, c. 10, Sched. Q, s. 13 - no effect - see 2009, c. 26, s. 10 (1) - 15/12/2009; 2007, c. 10, Sched. R, s. 14 - no effect - see 2009, c. 26, s. 10 (1) - 15/12/2009

2009, c. 26, s. 10 (1) - 15/12/2009; 2009, c. 26, s. 10 (2) - 1/07/2015; 2009, c. 33, Sched. 18, s. 10 (1) - 15/12/2009

Meaning of "excluded act"

3. (1) In this section,

"excluded act" means,

(a) anything described in clause (b) or (g) of the definition of "treatment" in subsection 2 (1), or

(b) anything described in clause (h) of the definition of "treatment" in subsection 2 (1) and prescribed by the regulations as an excluded act. 1996, c. 2, Sched. A, s. 3 (1).

Excluded act considered treatment

(2) If a health practitioner decides to proceed as if an excluded act were a treatment for the purpose of this Act, this Act and the regulations apply as if the excluded act were a treatment within the meaning of this Act. 1996, c. 2, Sched. A, s. 3 (2).

Capacity

4. (1) A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. 1996, c. 2, Sched. A, s. 4 (1).

Presumption of capacity

(2) A person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services. 1996, c. 2, Sched. A, s. 4 (2).

Exception

(3) A person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment, the admission or the personal assistance service, as the case may be. 1996, c. 2, Sched. A, s. 4 (3).

Wishes

5. (1) A person may, while capable, express wishes with respect to treatment, admission to a care facility or a personal assistance service. 1996, c. 2, Sched. A, s. 5 (1).

Manner of expression

(2) Wishes may be expressed in a power of attorney, in a form prescribed by the regulations, in any other written form, orally or in any other manner. 1996, c. 2, Sched. A, s. 5 (2).

Later wishes prevail

(3) Later wishes expressed while capable prevail over earlier wishes. 1996, c. 2, Sched. A, s. 5 (3).

Research, sterilization, transplants

6. This Act does not affect the law relating to giving or refusing consent on another person's behalf to any of the following procedures:

1. A procedure whose primary purpose is research.
2. Sterilization that is not medically necessary for the protection of the person's health.
3. The removal of regenerative or non-regenerative tissue for implantation in another person's body. 1996, c. 2, Sched. A, s. 6.

Restraint, confinement

7. This Act does not affect the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others. 1996, c. 2, Sched. A, s. 7.

PART II
TREATMENT

GENERAL

Application of Part

8. (1) Subject to section 3, this Part applies to treatment. 1996, c. 2, Sched. A, s. 8 (1).

Law not affected

(2) Subject to section 3, this Part does not affect the law relating to giving or refusing consent to anything not included in the definition of "treatment" in subsection 2 (1). 1996, c. 2, Sched. A, s. 8 (2).

Meaning of "substitute decision-maker"

9. In this Part,

"substitute decision-maker" means a person who is authorized under section 20 to give or refuse consent to a treatment on behalf of a person who is incapable with respect to the treatment. 1996, c. 2, Sched. A, s. 9.

CONSENT TO TREATMENT

No treatment without consent

10. (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

(a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or

(b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent

on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1).

Opinion of Board or court governs

(2) If the health practitioner is of the opinion that the person is incapable with respect to the treatment, but the person is found to be capable with respect to the treatment by the Board on an application for review of the health practitioner's finding, or by a court on an appeal of the Board's decision, the health practitioner shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless the person has given consent. 1996, c. 2, Sched. A, s. 10 (2).

Elements of consent

11. (1) The following are the elements required for consent to treatment:

1. The consent must relate to the treatment.

2. The consent must be informed.

3. The consent must be given voluntarily.

4. The consent must not be obtained through misrepresentation or fraud. 1996, c. 2, Sched. A, s. 11 (1).

Informed consent

(2) A consent to treatment is informed if, before giving it,

(a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and

(b) the person received responses to his or her requests for additional information about those matters. 1996, c. 2, Sched. A, s. 11 (2).

Same

(3) The matters referred to in subsection (2) are:

1. The nature of the treatment.
2. The expected benefits of the treatment.
3. The material risks of the treatment.
4. The material side effects of the treatment.
5. Alternative courses of action.
6. The likely consequences of not having the treatment. 1996, c. 2, Sched. A, s. 11 (3).

Express or implied

(4) Consent to treatment may be express or implied. 1996, c. 2, Sched. A, s. 11 (4).

Included consent

12. Unless it is not reasonable to do so in the circumstances, a health practitioner is entitled to presume that consent to a treatment includes,

(a) consent to variations or adjustments in the treatment, if the nature, expected benefits, material risks and material side effects of the changed treatment are not significantly different from the nature, expected benefits, material risks and material side effects of the original treatment; and

(b) consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks or material side effects of the treatment as a result of the change in the setting in which it is administered. 1996, c. 2, Sched. A, s. 12.

Plan of treatment

13. If a plan of treatment is to be proposed for a person, one health practitioner may, on behalf of all the health practitioners involved in the plan of treatment,

(a) propose the plan of treatment;

(b) determine the person's capacity with respect to the treatments referred to in the plan of treatment; and

(c) obtain a consent or refusal of consent in accordance with this Act,

(i) from the person, concerning the treatments with respect to which the person is found to be capable, and

(ii) from the person's substitute decision-maker, concerning the treatments with respect to which the person is found to be incapable. 1996, c. 2, Sched. A, s. 13.

Withdrawal of consent

14. A consent that has been given by or on behalf of the person for whom the treatment was proposed may be withdrawn at any time,

(a) by the person, if the person is capable with respect to the treatment at the time of the withdrawal;

(b) by the person's substitute decision-maker, if the person is incapable with respect to the treatment at the time of the withdrawal. 1996, c. 2, Sched. A, s. 14.

CAPACITY

Capacity depends on treatment

15. (1) A person may be incapable with respect to some treatments and capable with respect to others. 1996, c. 2, Sched. A, s. 15 (1).

Capacity depends on time

(2) A person may be incapable with respect to a treatment at one time and capable at another. 1996, c. 2, Sched. A, s. 15 (2).

Return of capacity

16. If, after consent to a treatment is given or refused on a person's behalf in accordance with this Act, the person becomes capable with respect to the treatment in the opinion of the health practitioner, the person's own decision to give or refuse consent to the treatment governs. 1996, c. 2, Sched. A, s. 16.

Information

17. A health practitioner shall, in the circumstances and manner specified in guidelines established by the governing body of the health practitioner's profession, provide to persons found by the health practitioner to be incapable with respect to treatment such information about the consequences of the findings as is specified in the guidelines. 1996, c. 2, Sched. A, s. 17.

Treatment must not begin

18. (1) This section applies if,

(a) a health practitioner proposes a treatment for a person and finds that the person is incapable with respect to the treatment;

(b) before the treatment is begun, the health practitioner is informed that the person intends to apply, or has applied, to the Board for a review of the finding; and

(c) the application to the Board is not prohibited by subsection 32 (2). 1996, c. 2, Sched. A, s. 18 (1).

Same

(2) This section also applies if,

(a) a health practitioner proposes a treatment for a person and finds that the person is incapable with respect to the treatment;

(b) before the treatment is begun, the health practitioner is informed that,

(i) the incapable person intends to apply, or has applied, to the Board for appointment of a representative to give or refuse consent to the treatment on his or her behalf, or

(ii) another person intends to apply, or has applied, to the Board to be appointed as the representative of the incapable person to give or refuse consent to the treatment on his or her behalf; and

(c) the application to the Board is not prohibited by subsection 33 (3). 1996, c. 2, Sched. A, s. 18 (2).

Same

(3) In the circumstances described in subsections (1) and (2), the health practitioner shall not begin the treatment, and shall take reasonable steps to ensure that the treatment is not begun,

(a) until 48 hours have elapsed since the health practitioner was first informed of the intended application to the Board without an application being made;

(b) until the application to the Board has been withdrawn;

(c) until the Board has rendered a decision in the matter, if none of the parties to the application before the Board has informed the health practitioner that he or she intends to appeal the Board's decision; or

(d) if a party to the application before the Board has informed the health practitioner that he or she intends to appeal the Board's decision,

(i) until the period for commencing the appeal has elapsed without an appeal being commenced, or

(ii) until the appeal of the Board's decision has been finally disposed of. 1996, c. 2, Sched. A, s. 18 (3).

Emergency

(4) This section does not apply if the health practitioner is of the opinion that there is an emergency within the meaning of subsection 25 (1). 1996, c. 2, Sched. A, s. 18 (4).

Order authorizing treatment pending appeal

19. (1) If an appeal is taken from a Board or court decision that has the effect of authorizing a person to consent to a treatment, the treatment may be administered before the final disposition of the appeal, despite section 18, if the court to which the appeal is taken so orders and the consent is given. 1996, c. 2, Sched. A, s. 19 (1).

Criteria for order

(2) The court may make the order if it is satisfied,

(a) that,

(i) the treatment will or is likely to improve substantially the condition of the person to whom it is to be administered, and the person's condition will not or is not likely to improve without the treatment, or

(13) ONTARIO MENTAL HEALTH ACT

Français

Mental Health Act

R.S.O. 1990, CHAPTER M.7

Consolidation Period: From December 21, 2015 to the e-Laws currency date.

Last amendment: 2015, c. 36, s. 1-16.

CONTENTS

Definitions

1. (1) In this Act,

"attending physician" means a physician to whom responsibility for the observation, care and treatment of a patient has been assigned; ("médecin traitant")

"Board" means the Consent and Capacity Board continued under the *Health Care Consent Act, 1996*; ("Commission")

"community treatment plan" means a plan described in section 33.7 that is a required part of a community treatment order; ("plan de traitement en milieu communautaire")

"Deputy Minister" means the deputy minister of the Minister; ("sous-ministre")

"health practitioner" has the same meaning as in the *Health Care Consent Act, 1996*; ("praticien de la santé")

"informal patient" means a person who is a patient in a psychiatric facility, having been admitted with the consent of another person under section 24 of the *Health Care Consent Act, 1996*; ("malade en cure facultative")

"involuntary patient" means a person who is detained in a psychiatric facility under a certificate of involuntary admission, a certificate of renewal or a certificate of continuation; ("malade en cure obligatoire")

"local board of health" has the same meaning as board of health in the *Health Protection and Promotion Act*; ("conseil local de santé")

"medical officer of health" has the same meaning as in the *Health Protection and Promotion Act*; ("médecin-hygiéniste")

"mental disorder" means any disease or disability of the mind; ("trouble mental")

"Minister" means the Minister of Health and Long-Term Care or such other member of the Executive Council as the Lieutenant Governor in Council designates; ("ministre")

"Ministry" means the Ministry of the Minister; ("ministère")

"officer in charge" means the officer who is responsible for the administration and management of a psychiatric facility; ("dirigeant responsable")

"out-patient" means a person who is registered in a psychiatric facility for observation or treatment or both, but who is not admitted as a patient and is not the subject of an application for assessment; ("malade externe")

"patient" means a person who is under observation, care and treatment in a psychiatric facility; ("malade")

"personal health information" has the same meaning as in the *Personal Health Information Protection Act, 2004*; ("renseignements personnels sur la santé")

"physician" means a legally qualified medical practitioner and, when referring to a community treatment order, means a legally qualified medical practitioner who meets the qualifications prescribed in the regulations for the issuing or renewing of a community treatment order; ("médecin")

"plan of treatment" has the same meaning as in the *Health Care Consent Act, 1996*; ("plan de traitement")

"prescribed" means prescribed by the regulations; ("prescrit")

"psychiatric facility" means a facility for the observation, care and treatment of persons suffering from mental disorder, and designated as such by the Minister; ("établissement psychiatrique")

"psychiatrist" means a physician who holds a specialist's certificate in psychiatry issued by The Royal College of Physicians and Surgeons of Canada or equivalent qualification acceptable to the Minister; ("psychiatre")

"record of personal health information", in relation to a person, means a record of personal health information that is compiled in a psychiatric facility in respect of the person; ("dossier de renseignements personnels sur la santé")

"registered nurse in the extended class" means a registered nurse who holds an extended certificate of registration under the *Nursing Act, 1991*; ("infirmière autorisée ou infirmier autorisé de la catégorie supérieure")

"regulations" means the regulations made under this Act; ("règlements")

"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; ("maîtriser")

"rights adviser" means a person, or a member of a category of persons, qualified to perform the functions of a rights adviser under this Act and designated by a psychiatric facility, the Minister or by the regulations to perform those functions, but does not include,

(a) a person involved in the direct clinical care of the person to whom the rights advice is to be given, or

(b) a person providing treatment or care and supervision under a community treatment plan; ("conseiller en matière de droits")

"senior physician" means the physician responsible for the clinical services in a psychiatric facility; ("médecin-chef")

"substitute decision-maker", in relation to a patient, means the person who would be authorized under the *Health Care Consent Act, 1996* to give or refuse consent to a treatment on behalf of the patient, if the patient were incapable with respect to the treatment under that Act, unless the context requires otherwise; ("mandataire spécial")

"treatment" has the same meaning as in the *Health Care Consent Act, 1996*. ("traitement") R.S.O. 1990, c. M.7, s. 1; 1992, c. 32, s. 20 (1-4); 1996, c. 2, s. 72 (1, 2, 4, 5); 2000, c. 9, s. 1; 2004, c. 3, Sched. A, s. 90 (1-3); 2015, c. 36, s. 2.

Meaning of "explain"

(2) A rights adviser or other person whom this Act requires to explain a matter satisfies that requirement by explaining the matter to the best of his or her ability and in a manner that addresses the special needs of the person receiving the explanation, whether that person understands it or not. 1992, c. 32, s. 20 (5).

2. REPEALED: 1992, c. 32, s. 20 (7).

3. REPEALED: 1992, c. 32, s. 20 (7).

4. REPEALED: 1992, c. 32, s. 20 (7).

5. REPEALED: 1992, c. 32, s. 20 (7).

Effect of Act on rights and privileges

6. Nothing in this Act shall be deemed to affect the rights or privileges of any person except as specifically set out in this Act. R.S.O. 1990, c. M.7, s. 6.

PART I
STANDARDS

Application of Act

7. This Act applies to every psychiatric facility. R.S.O. 1990, c. M.7, s. 7.

Conflict

8. Every psychiatric facility has power to carry on its undertaking as authorized by any Act, but, where the provisions of any Act conflict with the provisions of this Act or the regulations, the provisions of this Act and the regulations prevail. R.S.O. 1990, c. M.7, s. 8.

Advisory officers

9. (1) The Minister may designate officers of the Ministry or appoint persons who shall advise and assist medical officers of health, local boards of health, hospitals and other bodies and persons in all matters pertaining to mental health and who shall have such other duties as are assigned to them by this Act or the regulations.

Powers

(2) Any such officer or person may at any time, and shall be permitted so to do by the authorities thereat, visit and inspect any psychiatric facility, and in so doing may interview patients, examine books, records and other documents relating to patients, examine the condition of the psychiatric facility and its equipment, and inquire into the adequacy of its staff, the range of services provided and any other matter he or she considers relevant to the maintenance of standards of patient care. R.S.O. 1990, c. M.7, s. 9.

Provincial aid

10. The Minister may pay psychiatric facilities provincial aid in such manner, in such amounts and on such conditions as he or she considers appropriate. 1997, c. 15, s. 11 (1).

PART II
HOSPITALIZATION

Where admission may be refused

11. Despite this or any other Act, admission to a psychiatric facility may be refused where the immediate needs in the case of the proposed patient are such that hospitalization is not urgent or necessary. R.S.O. 1990, c. M.7, s. 11.

Admission of informal or voluntary patients

12. Any person who is believed to be in need of the observation, care and treatment provided in a psychiatric facility may be admitted thereto as an informal or voluntary patient upon the recommendation of a physician. R.S.O. 1990, c. M.7, s. 12.

Child as informal patient

13. (1) A child who is twelve years of age or older but less than sixteen years of age, who is an informal patient in a psychiatric facility and who has not so applied within the preceding three months may apply in the approved form to the Board to inquire into whether the child needs observation, care and treatment in the psychiatric facility. R.S.O. 1990, c. M.7, s. 13 (1); 1992, c. 32, s. 20 (6); 2000, c. 9, s. 2 (1).

Application deemed made

(2) Upon the completion of six months after the later of the child's admission to the psychiatric facility as an informal patient or the child's last application under subsection (1), the child shall be deemed to have applied to the Board in the approved form under subsection (1). R.S.O. 1990, c. M.7, s. 13 (2); 1992, c. 32, s. 20 (6); 2000, c. 9, s. 2 (2).

Considerations

(3) In determining whether the child needs observation, care and treatment in the psychiatric facility, the Board shall consider,

(a) whether the child needs observation, care and treatment of a kind that the psychiatric facility can provide;

(b) whether the child's needs can be adequately met if the child is not an informal patient in the psychiatric facility;

(c) whether there is an available alternative to the psychiatric facility in which the child's needs could be more appropriately met;

(d) the child's views and wishes, where they can be reasonably ascertained; and

(e) any other matter that the Board considers relevant. R.S.O. 1990, c. M.7, s. 13 (3); 1992, c. 32, s. 20 (6).

Powers of Board

(4) The Board by an order in writing may,

(a) direct that the child be discharged from the psychiatric facility; or

(b) confirm that the child may be continued as an informal patient in the psychiatric facility. R.S.O. 1990, c. M.7, s. 13 (4); 1992, c. 32, s. 20 (6).

No limitation

(5) Nothing in this section prevents a physician from completing a certificate of involuntary admission in respect of the child. R.S.O. 1990, c. M.7, s. 13 (5).

Panels of three or five members

(6) Despite subsection 73 (1) of the *Health Care Consent Act, 1996*, the chair shall assign the members of the Board to sit in panels of three or five members to deal with applications under this section. 1996, c. 2, s. 72 (6).

Procedure

(7) Subsection 39 (14) and section 42 of this Act and clause 73 (3) (a), subsection 73 (4) and sections 74 to 80 of the *Health Care Consent Act, 1996* apply to an application under this section, with necessary modifications. 1996, c. 2, s. 72 (6); 2015, c. 36, s. 3.

Informal or voluntary patient

14. Nothing in this Act authorizes a psychiatric facility to detain or to restrain an informal or voluntary patient. R.S.O. 1990, c. M.7, s. 14.

Application for psychiatric assessment

15. (1) Where a physician examines a person and has reasonable cause to believe that the person,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

(c) has shown or is showing a lack of competence to care for himself or herself,

and if in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) serious physical impairment of the person,

the physician may make application in the prescribed form for a psychiatric assessment of the person. R.S.O. 1990, c. M.7, s. 15 (1); 2000, c. 9, s. 3 (1).

Same

(1.1) Where a physician examines a person and has reasonable cause to believe that the person,

(a) has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person; and

(b) has shown clinical improvement as a result of the treatment,

and if in addition the physician is of the opinion that the person,

(c) is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

(d) given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment; and

(e) is incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained,

the physician may make application in the prescribed form for a psychiatric assessment of the person. 2000, c. 9, s. 3 (2).

Contents of application

(2) An application under subsection (1) or (1.1) shall set out clearly that the physician who signs the application personally examined the person who is the subject of the application and made careful inquiry into all of the facts necessary for him or her to form his or her opinion as to the nature and quality of the mental disorder of the person. R.S.O. 1990, c. M.7, s. 15 (2); 2000, c. 9, s. 3 (3).

Idem

(3) A physician who signs an application under subsection (1) or (1.1),

(a) shall set out in the application the facts upon which he or she formed his or her opinion as to the nature and quality of the mental disorder;

(b) shall distinguish in the application between the facts observed by him or her and the facts communicated to him or her by others; and

(c) shall note in the application the date on which he or she examined the person who is the subject of the application. R.S.O. 1990, c. M.7, s. 15 (3); 2000, c. 9, s. 3 (4).

Signing of application

(4) An application under subsection (1) or (1.1) is not effective unless it is signed by the physician within seven days after he or she examined the person who is the subject of the examination. R.S.O. 1990, c. M.7, s. 15 (4); 2000, c. 9, s. 3 (5).

Authority of application

(5) An application under subsection (1) or (1.1) is sufficient authority for seven days from and including the day on which it is signed by the physician,

(a) to any person to take the person who is the subject of the application in custody to a psychiatric facility forthwith; and

(b) to detain the person who is the subject of the application in a psychiatric facility and to restrain, observe and examine him or her in the facility for not more than 72 hours. R.S.O. 1990, c. M.7, s. 15 (5); 2000, c. 9, s. 3 (6).

Justice of the peace's order for psychiatric examination

16. (1) Where information upon oath is brought before a justice of the peace that a person within the limits of the jurisdiction of the justice,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

(c) has shown or is showing a lack of competence to care for himself or herself,

and in addition based upon the information before him or her the justice of the peace has reasonable cause to believe that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) serious physical impairment of the person,

the justice of the peace may issue an order in the prescribed form for the examination of the person by a physician. R.S.O. 1990, c. M.7, s. 16 (1); 2000, c. 9, s. 4 (1).

Same

(1.1) Where information upon oath is brought before a justice of the peace that a person within the limits of the jurisdiction of the justice,

(a) has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person; and

(b) has shown clinical improvement as a result of the treatment,

and in addition based upon the information before him or her the justice of the peace has reasonable cause to believe that the person,

(c) is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

(d) given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment; and

(e) is apparently incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained,

the justice of the peace may issue an order in the prescribed form for the examination of the person by a physician. 2000, c. 9, s. 4 (2).

Idem

(2) An order under this section may be directed to all or any police officers of the locality within which the justice has jurisdiction and shall name or otherwise describe the person with respect to whom the order has been made. R.S.O. 1990, c. M.7, s. 16 (2); 2000, c. 9, s. 4 (3).

Authority of order

(3) An order under this section shall direct, and, for a period not to exceed seven days from and including the day that it is made, is sufficient authority for any police officer to whom it is addressed to take the person named or described therein in custody forthwith to an appropriate place where he or she may be detained for examination by a physician. R.S.O. 1990, c. M.7, s. 16 (3); 2000, c. 9, s. 4 (4).

Manner of bringing information before justice

(4) For the purposes of this section, information shall be brought before a justice of the peace in the prescribed manner. 2000, c. 9, s. 4 (5).

Action by police officer

17. Where a police officer has reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner and has reasonable cause to believe that the person,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

(c) has shown or is showing a lack of competence to care for himself or herself,

and in addition the police officer is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) serious physical impairment of the person,

and that it would be dangerous to proceed under section 16, the police officer may take the person in custody to an appropriate place for examination by a physician. 2000, c. 9, s. 5.

Place of psychiatric examination

18. An examination under section 16 or 17 shall be conducted by a physician forthwith after receipt of the person at the place of examination and where practicable the place shall be a psychiatric facility or other health facility. R.S.O. 1990, c. M.7, s. 18.

Change from informal or voluntary patient to involuntary patient

19. Subject to subsections 20 (1.1) and (5), the attending physician may change the status of an informal or voluntary patient to that of an involuntary patient by completing and filing with the officer in charge a certificate of involuntary admission. R.S.O. 1990, c. M.7, s. 19; 2000, c. 9, s. 6.

Duty of attending physician

20. (1) The attending physician, after observing and examining a person who is the subject of an application for assessment under section 15 or who is the subject of an order under section 32,

(a) shall release the person from the psychiatric facility if the attending physician is of the opinion that the person is not in need of the treatment provided in a psychiatric facility;

(b) shall admit the person as an informal or voluntary patient if the attending physician is of the opinion that the person is suffering from mental disorder of such a nature or quality that the person is in need of the treatment provided in a psychiatric facility and is suitable for admission as an informal or voluntary patient; or

(c) shall admit the person as an involuntary patient by completing and filing with the officer in charge a certificate of involuntary admission if the attending physician is of the opinion that the conditions set out in subsection (1.1) or (5) are met. R.S.O. 1990, c. M.7, s. 20 (1); 2000, c. 9, s. 7 (1).

Conditions for involuntary admission

(1.1) The attending physician shall complete a certificate of involuntary admission, a certificate of renewal or a certificate of continuation if, after examining the patient, he or she is of the opinion that the patient,

(a) has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person;

(b) has shown clinical improvement as a result of the treatment;

(c) is suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

(d) given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment;

(e) has been found incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained; and

(f) is not suitable for admission or continuation as an informal or voluntary patient. 2000, c. 9, s. 7 (2); 2015, c. 36, s. 1.

Physician who completes certificate of involuntary admission

(2) The physician who completes a certificate of involuntary admission pursuant to clause (1) (c) shall not be the same physician who completed the application for psychiatric assessment under section 15. R.S.O. 1990, c. M.7, s. 20 (2).

Release of person by officer in charge

(3) The officer in charge shall release a person who is the subject of an application for assessment under section 15 or who is the subject of an order under section 32 upon the completion of 72 hours of detention in the psychiatric facility unless the attending physician has released the person, has admitted the person as an informal or voluntary patient or has admitted the person as an involuntary patient by completing and filing with the officer in charge a certificate of involuntary admission. R.S.O. 1990, c. M.7, s. 20 (3).

Authority of certificate

(4) An involuntary patient may be detained, restrained, observed and examined in a psychiatric facility,

(a) for not more than two weeks under a certificate of involuntary admission; and

(b) for not more than,

(i) one additional month under a first certificate of renewal,

(ii) two additional months under a second certificate of renewal,

(iii) three additional months under a third certificate of renewal, and

(iv) three additional months under a first or subsequent certificate of continuation,

that is completed and filed with the officer in charge by the attending physician. R.S.O. 1990, c. M.7, s. 20 (4); 2015, c. 36, s. 4 (1).

Conditions for involuntary admission

(5) The attending physician shall complete a certificate of involuntary admission, a certificate of renewal or a certificate of continuation if, after examining the patient, he or she is of the opinion both,

(a) that the patient is suffering from mental disorder of a nature or quality that likely will result in,

(i) serious bodily harm to the patient,

(ii) serious bodily harm to another person, or

(iii) serious physical impairment of the patient,

unless the patient remains in the custody of a psychiatric facility; and

(b) that the patient is not suitable for admission or continuation as an informal or voluntary patient. R.S.O. 1990, c. M.7, s. 20 (5); 2000, c. 9, s. 7 (3, 4); 2015, c. 36, s. 1.

Change of status, where period of detention has expired

(6) An involuntary patient whose authorized period of detention has expired shall be deemed to be an informal or voluntary patient. R.S.O. 1990, c. M.7, s. 20 (6).

Idem, where period of detention has not expired

(7) An involuntary patient whose authorized period of detention has not expired may be continued as an informal or voluntary patient upon completion of the approved form by the attending physician. R.S.O. 1990, c. M.7, s. 20 (7); 2000, c. 9, s. 7 (5).

Examination of certificate by officer in charge

(15) THE CENTRE FOR ADDICTION AND MENTAL HEALTH BILL OF RIGHTS

The Centre for Addiction and Mental Health
Bill of Client Rights

Preamble

The Bill of Client Rights has been developed to assert and promote the dignity and worth of all of the people who use the services of the Centre for Addiction and Mental Health (CAMH). The Bill of Client Rights expresses the truth that clients are first and foremost human beings with the same rights as every Canadian. The clients, families and staff of CAMH who have worked together to develop the Bill of Client Rights want it to be a living document that will grow and change as it helps to create an organizational culture of mutual respect. The Bill of Client Rights is intended to emphasize the rights of clients rather than organizational convenience. Policies at CAMH should be consistent with the Bill of Client Rights.

CAMH is committed to upholding all the rights of people under the law. The rights outlined in the Bill of Client Rights may be restricted by law or by order of a court or Review Board; or, they may be restricted reasonably to ensure the protection of the rights and safety of the individual and/or others. The restriction of some rights leaves other rights intact.

The Board of Trustees of the Centre for Addiction and Mental Health endorses the Bill of

Client Rights and, in so doing, creates a number of expectations: that the Centre for Addiction and Mental Health and every one working at CAMH – including volunteers and students – will respect and uphold the Bill of Client Rights; will promote awareness and understanding of the Bill of Client Rights; and will interpret the Bill of Client Rights as broadly and generously as is consistent with its responsibility to clients collectively. **Every client has the right to be provided with a written copy of, and assistance in understanding the Bill of Client Rights, and to have it posted at CAMH's main entrances and wherever clients receive services.**

Right #1

Right to be Treated with Respect Every client:

5) **is a person first, and has the right to be treated with respect.**

6) **has the right to be treated in a respectful manner, regardless of her/his race, culture, colour, religion, sex, age, mental or physical disability, class/economic position, sexual orientation, gender identity, diagnosis, inpatient status, or legal status.**
7) **has the right to have her/his privacy respected.**

8) **has the right to respect of her/his needs, wishes, values, beliefs and experience.**

Right #2

Right to Freedom from Harm

Every client:

3) has the right to a safe environment while a client at CAMH.

4) has the right to be free from physical, sexual, verbal, emotional and financial abuse. CAMH will use its best efforts to protect clients from harm. CAMH will assist clients who experience abuse.

5) has the right to be free from discrimination, harassment, retribution, punishment and exploitation.

6) **has the right not to be coerced or detained except where permitted by law.**

7) **has the right to be free from locked seclusion, environmental, chemical and mechanical restraint except where permitted by law. (i.e. when a client is a danger to self or others). Only the minimum necessary amount of restraint or locked seclusion is allowed and only after alternative methods of resolution have been unsuccessful. Clients have the right to be informed of how they can be released from restraints or seclusion.**

8) has the right to care based on support and healing.

Right #3

Right to Dignity and Independence Every client:

3) has the right to be informed promptly that she/he is no longer an involuntary patient when the client successfully appeals a form of involuntary admission. She/he must be informed that she/he may leave the hospital and be allowed to leave.

4) **has the right to have services provided in a manner that respects the dignity, independence and self-determination of the individual.**

5) has the right to private communication with others in accordance with the law.

6) **has the right to confidentiality about personal information and records in accordance with the law.**

7) has the right to contact with clergy or other spiritual advisors of her/his choice, and to exercise religious and spiritual observances, rituals, customs, and dress.

8) has the right to retain and use personal possessions, with access to secure storage, in keeping with safety requirements and other clients' rights.

9) has the right to wear their own clothing.

10) has the right to manage her/his own financial resources unless found to be financially incapable. This right includes access to her/his money and to accurate information about her/his hospital account.

11) has the right to be recognized as having needs for privacy and intimacy, including sexual expression between consenting adults. This includes access to privacy, information and education regarding safer sex, and forms of contraception and protection from sexually transmitted diseases.

12) has the right, if eligible, to vote in any election, and to receive the necessary information to be enumerated and to vote, as well as assistance in getting to the polling station, if on hospital premises.

13) has the right to all freedoms in accordance with the law.

Right #4

Right to Quality Services that Comply with Standards Every client:

5) **has the right to have services provided in a manner that complies with legal, professional, ethical, and other relevant standards.**

6) has the right to identify their own needs, to have those needs form the basis of the development of a plan for services, and to have services provided in accordance with that plan.

7) has the right to fair and equitable access to a range of services.

8) **has the right to a choice of services, and will not be denied other options if the client does not choose one treatment or service.**

9) has the right to have their record identify sources of data, record only relevant and useful facts, and avoid unfounded conclusions, prejudice, value judgements and labelling.

10) has the right to access care without undue difficulty to meet basic needs.
Every client has the right to reasonable accommodations required to access services.

11) **has a right to choose the least restrictive care.**

12) **has the right to have services provided in a manner that minimizes potential harm, and optimizes quality of life.**

13) has the right to co-operation and collaboration among providers to ensure quality and continuity of client centred care (including integration with other healing practices), in support of wellness and recovery.

14) has the right to be informed of the name and staff title of those providing services to her/him, to express a preference and to have that preference considered.

15) has the right to sufficient, nutritious and palatable food, in accordance with medical and religious requirements, and with consideration of personal and cultural choices.

16) has the right to daily access to the outdoors.

17) has the right to regular, consistent access to educational and recreational activities. 14) has the right to a quiet, safe and secure sleeping environment.

15) has the right to: participate in creating an individualized, written plan of care and service; consent to it; and receive a copy of it.

16) **has the right to seek an additional medical opinion**.

17) has the right to assistance with meeting their basic needs, accessing education and vocational training, income, getting identification, housing, employment, social supports and health care.

18) has the right to be involved in their discharge planning, and to have access to information about various support options available in the community, including self-help organizations.

19) has the right to access toilet facilities with all possible privacy.

Right #5

Right to Effective Communication Every client:

1) has the right to effective communication in a form, language, and manner that assists the client to understand the information provided. Where necessary, this includes the right to a competent interpreter.

2) has the right to an environment that enables both client and provider to communicate openly, honestly and effectively.

Right #6

Right to be Fully Informed Every client:

2) **has the right to be informed of her/his rights in this Bill of Client Rights**

3) and substitute decision maker or appointed representative has the right to information, including written information on request, of:

   a. The perceived problem, diagnosis or condition.

   b. The treatment that is proposed.

   c. An explanation of the alternative options/treatments including no treatment.

   d. An assessment of the benefits, risks (short term and long term), side effects, and costs of these options.

   e. Additional medication related information such as drug interactions, dosages, and withdrawal effects.

   f. The results of tests and procedures.

4) has the right to honest and accurate answers to questions relating to services, including questions about:

   a. The name and qualifications of the provider.

   b. The recommendations for treatments or services.

   c. How to obtain an opinion from another provider.

   d. Where to access additional information if wanted.

e. Notification of developments in the area of treatment affecting the client.

5) has the right to view her/his clinical record without undue difficulty.

6) has the right to have her/his clinical record corrected or to add a statement of disagreement to it in accordance with the law.

7) has the right to information requested about services and procedures relevant to being a CAMH client, such as rules, policies and rights that apply to her/him at the CAMH, and have access to them in writing.

Right #7

Right to Make an Informed Choice, and Give Informed Consent to Treatment

8) **No treatment shall be given without the client's informed consent, except in accordance with the law.**

9) **Consent must be for that particular treatment or plan of treatment.**

10) **Consent can be withdrawn at any time.**

11) Information about the treatment must be provided in writing on request.
Every effort must be made to promote understanding and access to information about proposed treatments.

12) **Every client is presumed to have decision-making capacity unless found to be incapable.**

13) **Consent must be voluntary and not obtained by coercion or misrepresentation.**

14) If a client is legally found to be incapable of making decisions, her/his substitute decision-maker has the same rights as the client to informed consent.

Every client:

15) **has the right to have her/his prior capable wishes respected to the fullest extent that the law allows.**

16) **has the right to be fully involved in treatment decisions (including location, duration and type of treatment).**

17) including those considered incapable of making treatment decisions, has the right to be involved in the development of her/his treatment goals, plan of care and discharge planning.

Right #8

The Right to Support Every client:

1) has the right to visits from one or more support persons (e.g. family, friends, partner - including same sex partner, community support) of her/his choice, and assistance in contacting them.

2) has the right to request the presence of a third party during a physical examination.

3) has the right to access confidential support when needed: counselling, rights advice, advocacy, legal counsel, other supports of his or her choice.

4) has the right to assistance in obtaining: financial support, housing, recreation, employment supports, social support, and community supports in keeping with her/his needs and wishes.

Right #9

Rights in Respect of Research or Teaching Every client:

1) has the right to decline involvement in research at any time and to know that declining participation will not affect her/his access to care, treatment or future service provision.

2) who is not eligible for research has the right to be informed of treatment options available to her/him.

3) has the right to give informed consent to participate in research, including risks, and whether this treatment is new (or new for this purpose).

4) has the right to be advised when students are involved and to decline student involvement in any part of her/his treatment, except in the case of psychiatric residents.

5) research participant has the right to be informed of what the research study is about, and the results of the research in summary form.

Right #10

Right to Complain Every client:

3) **has the right to make a complaint, access advocacy and to make suggestions and inquiries.**

4) has the right to make a complaint without retribution.

5) can make a complaint to: the individual(s) who provided the service, the Client Relations Coordinator, the Psychiatric Patient Advocate Office, or any other person(s).

6) **has the right to inform the Empowerment Council or Family Council of her/his complaint(s), in order to seek changes in the system.**

7) The client will be informed of any relevant internal or external complaints procedures.

8) In the case of complaints made through the Centre's complaint process:

- Every client has the right to have a person of her/his choice to support him or her through the complaint process.
- Staff must facilitate the fair, simple, speedy and efficient resolution of

complaints.

- The complaint will be acknowledged and documented. The client will be

informed of the progress of the client's complaint, in writing if requested.

- All complaints resolutions will be consistent with this Bill of Client Rights.

The complaints process described above applies to the CAMH Client Relations Office.

This is the internal CAMH mechanism for complaints. The Psychiatric Patient Advocate Office offers independent, individual advocacy for clients. The Empowerment Council offers independent systemic advocacy for clients.

(15) THE CAMH EMPOWERMENT COUNCIL

Empowerment Council

A Voice for the Clients of the Centre for Addiction and Mental Health

Mission Statement:

The Empowerment Council is a voice for clients/survivors and ex-clients of mental health and addiction services, primarily of CAMH.

Statement of Purpose:

To conduct system wide advocacy on behalf of clients and ex-clients.

From the CAMH/EC Memorandum of Understanding: "CAMH and the Empowerment Council acknowledge the key role played by clients in the ability of CAMH to deliver client centred care."

Terms of Reference

The Organization

The Empowerment Council takes its direction from clients and is funded by CAMH. The EC is an independent incorporated organization consisting entirely of people who have received mental health or/and addiction services. The EC client membership elects a Board of 10 people, two from each of the four CAMH sites, and two from the community. The EC staff consists of a full-time Coordinator and two half time Outreach workers. At this time there is also an additional half time position dedicated to teaching the CAMH Bill of Client Rights.

The Empowerment Council Agenda:

Within the limits of the resources of the organization.

Advocacy

The Empowerment Council will:

- Advocate on a systemic level (e.g. to C.A.M.H., various levels of government, in the judicial system) on behalf of addiction and mental health clients. The EC will place clients self identified needs first, and communicate through various means for greatest effectiveness.

- Consolidate the client voice through consultations, surveys, election of representatives

Please note that while it is helpful to know of individual advocacy issues to inform the EC voice on clients' behalf, the Empowerment Council does not conduct individual advocacy - for this we refer people to the Patient Advocate Office or the Client Relations Coordinator

Representation

The Empowerment Council will:

- Ensure the representation of the client perspective at CAMH through significant participation on relevant committees, work groups, and other decision-making and accountability structures.

- Communicate with clients on committees, and evaluate the influence of client involvement on CAMH policies and practices

Outreach and Community Development

The Empowerment Council will:

- Conduct outreach and community development with mental health and addiction clients of CAMH through site visits, meetings, consultations, events, etc.

Education and Information Sharing

The Empowerment Council will:

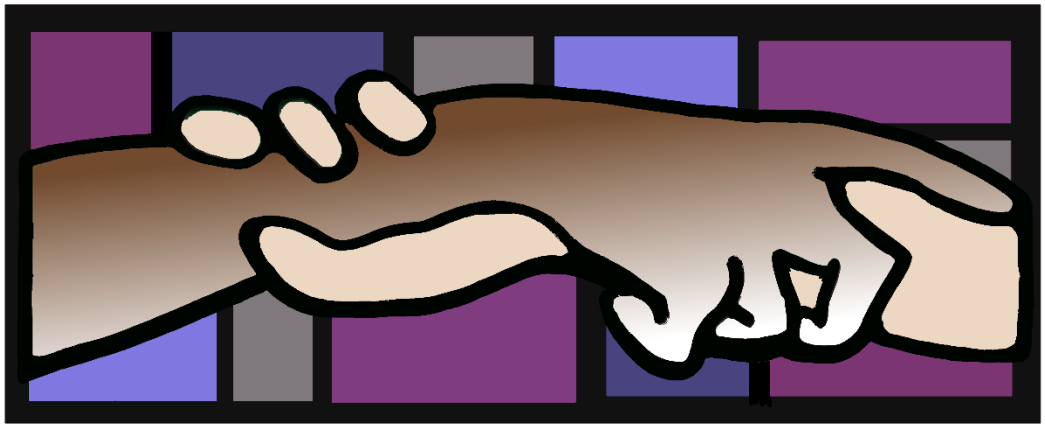
- Ensure client access to information, and educate clients in regard to choices, rights, self-advocacy, critical thinking, and other critical aspects of self-empowerment.

- Educate, sensitize, and provide training to mental health professionals, addiction workers, and other members of the community.

http://www.empowermentcouncil.ca/

(16) THE MENTAL HEALTH RIGHTS COALITION

MENTAL HEALTH RIGHTS COALITION



Our Organization

The Mental Health Rights Coalition of Hamilton is a non-profit organization funded by Ontario's Ministry of Health and Long Term Care as a Consumer/Survivor Initiative.

In this context, ***a consumer*** is a person who has a mental health issue.
A ***Consumer Survivor*** is a person who has been afflicted with a mental health issue and has learned to cope with that issue.
Consumer/Survivor Initiatives (CSIs) are consumer-driven agencies, which allow survivors to use their coping skills to help other consumers become survivors. Learn more about CSIs with the the "CSI Builder Report" or Consumer Survivor Initiatives in Ontario: Building for an Equitable Future

History

The Mental Health Rights Coalition (MHRC) was formed in 1991 by a group of Consumer/Survivors who were concerned about the province's move toward de-institutionalization in the absence of adequate and appropriate community supports and services. MHRC later became one of dozens of organizations that were funded in a provincial initiative to create CSIs. Find out more about our local CSIs at www.csilhin4.org MHRC was incorporated as a non-profit in 1995, and is governed by a volunteer Board of Directors and supported by paid staff.

Membership is free of charge to mental health consumers over the age of 18, and almost all of our programs and services are free of charge to consumer members. Family members and service providers are also free to join, but only those who have self-identified as consumer/survivors have voting privileges, can stand for election to the Board of Directors, or can be hired to work at MHRC. To sign up, please see our membership form on our contact page.

Our Services

Peer support

Peer support is the support provided by a person who has a similar lived experience, experienced recovery and is trained to provide listening and support.

Peer support is available in-person and on the telephone during drop-in hours.

We also provide training to those wishing to become peer support workers.

Find out more on our peer support page.

Drop-in centre

Mental Health Rights Coalition prides itself in having a safe and cozy place for consumers to visit during the day. As a member-driven organization, members are encouraged to take part in the planning of programs. During our monthly members' meeting, members provide feedback on drop in structure and calendar activities. The daily programming can be found on our calendar and newsletter.

Members are welcome to drop in for daily activities, socialize and partake in individual and self-led group activities and partake in peer support. Coffee is available for 25 cents. There is also available to members computers with internet, telephones and a resource library including books to read in the drop-in and community resource cards and brochures for the taking.

Systemic Advocacy

The Mental Health Rights Coalition advocates for its members through speaking up at various committees, attempting to create change through the system. This is different from individual advocacy in that we do not take on individual complaints; we use collective complaints as a catalyst for change.

(17) SUPPORTING STATEMENTS AND AFFIDAVITS

Affidavit

Tarik Leighton Carey

106 New Haven Court, Garner, North Carolina 27529, United States
Email: renewed@gmail.com, Mobile: 754-273-6534

I, Tarik Leighton Carey of 106 New Haven Court, Garner, North Carolina 27529, United States, have known Roxanne Stewart since childhood. I was diagnosed with bipolar disorder in 1995 and have been living with the condition for approximately 22 years. In my experience in Jamaica my right to consent to medical interventions and forced drug treatments have been ignored and violated both by my family members and by medical practitioners I have interfaced with.

Because of severe side effects I experienced on many of the psychotropic drugs I was put on, after 3 years I let my mother know I wanted to choose a more holistic approach to my mental health, such as through diet, exercise and meditation exercises. However this was not respected as my mother and sister continued to secretly put these drugs in my food and drink. Some of the severe side effects I experienced on these medications were symptoms of Tardive Dyskinesia such as tremors, being almost catatonic or stupefied, along with extreme somnolence.

However during periods when I would chose to come off these heavy medications, I would be able to maintain a job and go to school.

In approximately 2001, when I had been off these medications for a number of years and able to have some semblance of independence, my mother asked me to "say goodbye" to my psychiatrist who I had been seeing over the years. Once at his office, the doors were locked and I was locked in the building for an hour while an ambulance was called and I was forcibly taken to the University Hospital of the West Indies. I informed the doctors present that I did not consent to this treatment and when I attempted to leave the hospital I was held down and injected with Modecate, a very powerful antipsychotic.

Now living in the United States I have been better able to exercise my autonomy in managing my mental health and have better options available to me. I am able to have independence and currently work as a production technician at Konica Minolta and am also involved with my local church.

I believe persons with bipolar disorder or any psychiatric diagnosis should have the freedom to choose how to manage their condition and their rights to consent should be respected. Options and risks of different treatments should be evaluated and explained to them and persons shouldn't have to live in the constant fear of being involuntarily hospitalized especially if they pose no danger to themselves or others.

I, Tarik Leighton Carey, hereby state that all events and details aforementioned are true to the best of my knowledge and consent to this statement being used in the IRB hearing of Roxanne Stewart.

Sincerely,

Tarik Carey

Tarik Leighton Carey

Witnessed by,

JOSEPH C. IADONISI
Notary Public
Wake County
My Commission Expires
September 19, 2021
NORTH CAROLINA

_____, dated June 22, 2017

(Name of Notary Public)

Cameron Daniel Fray

175 Malvern Street, Scarborough Ontario M1B 1S7

Email: cjfray30@hotmail.com, Mobile: 416-906-0748

I, Cameron Daniel Fray, of 175 Malvern Street, Scarborough, Ontario, M1B 1S7, met the claimant, Roxanne Melissa Stewart in May of this year, 2017 through our church Toronto East Seventh Day Adventist church. I was diagnosed with bipolar disorder in 1998.

I am a husband and father and very active in my church. I am a truck driver for Rocket Ready Mix Incorporated and a musician as well as run the charity organization Daddy's House, mentoring men to be better father's for their children.

I can say even with the challenges of my condition I have been able to contribute to society through my church and through my charity while also being an attentive husband and father and believe that persons with psychiatric diagnoses ought to be given the right to live full productive lives contributing to their communities and families with their skills and talents.

I Cameron Daniel Fray do state that all the aforementioned is true to the best of my knowledge.

Sincerely,

X _____

Mr. Cameron Daniel Fray

Witnessed by:

_____

Willie James

André Anderson

A. Anderson (PASTOR)

(18) MEDICAL DIAGNOSIS/RECORDS: BUTLER HOSPITAL, MEDICAL ASSOCIATES HOSPITAL

TRANSFER/DISCHARGE SUMMARY PART I

BUTLER HOSPITAL, Providence, Rhode Island

Date Admitted: 4-22-05

Date ☐ Transferred ☒ Discharged 4-28-05

107780
STEWART, ROXEANNE
226 PLEASANT STREET
PROVIDENCE, RI 08/08/1981
DR L. SHEA HCVM

Name 04/22/2005 ~~DAY/OHP~~

MR# 2

FROM: AMA/Unplanned? ☐ yes ☒ no

Level of Care:
☐ acute inpatient ☐ residential inpatient
☐ observation bed ☒ partial hospital ☐ outpatient
☐ other

Program:
Unit/Site: PHP
Clinician: Shea

TO: ☐ No Further Treatment

Level of Care:
☐ acute inpatient ☐ residential inpatient
☐ observation bed ☐ partial hospital ☒ outpatient
☐ other

Program:
Unit/Site:
Clinician: Dr. Allen (Jamaica)

DIAGNOSES PRINCIPAL: ~~Bipo~~ ~~Psychotic Disorder NOS~~ bipolar I Disorder, manic, with psychotic features 296.44

Axis I: h/o Early Disorder NOS

Axis II: Deferred 799.9

Axis III: Obesity
Constipation 564.00

Axis IV: School

Axis V current 60-65 highest past year

IDENTIFYING INFORMATION AND REASON FOR TREATMENT

23yo Jamaican HISD graduate student transferred to PHP for further stabilization s/p inpt admit for acute psychosis.

SUMMARY OF CURRENT ASSESSMENT/TREATMENT Summarize response to medications, therapy, results of labs, consults, progress towards treatment goals.

attended PHP x 5 days. Individual / group treatment. Educated re: coping behavioral strategies to manage sx. Risperdal + valproic acid continued. Family very supportive + involved. Education re: illness + treatment. Neurology cons → labs + MRI ordered.

Last serum medication level: 4/27 90.5

CURRENT CONDITION/REASON FOR CHANGE IN LEVEL OF CARE Identify goals for further treatment or reason for ending treatment.

Improved & acute psychotic symptoms
She will be returning to Jamaica for follow up

discharged 4/28/05 ID 3303

CURRENT RISKS Active problems which may affect clinical course. Describe all positives.

☐ yes ☒ no Active Medical Problems:
☐ yes ☒ no Medication Allergies:
☐ yes ☒ no Suicidal:
☐ yes ☒ no Dangerous:
☐ yes ☒ no Substance Abuse:
☐ yes ☒ no Other: (compliance/abuse/legal/social/cultural):

4-28-05 (Date) | Dr. Rey MD (Signatures (s)) | Shea (Print Names(s))

MR 12 (Rev. 6-98 Kent) **DISTRIBUTION:** WHITE - Chart Copy, CANARY - CIS Copy

TRANSFER / DISCHARGE SUMMARY
PART II
PATIENT INSTRUCTIONS

BUTLER HOSPITAL
345 Blackstone Blvd.
Providence, Rhode Island

107780
STEWART, ROXEANNE
226 PLEASANT STREET
PROVIDENCE, RI 08/08/1981
DR L. SHEA HCVM

Name: 04/22/2005 DAY/DHP
MR #: 2

MEDICATIONS To be completed by physician or designee, not valid unless signed below by physician.

Name of Medication	❑ No Medication	Dose	Times to be taken
Valproic acid		250 mg	1 pill every morning and 2 pills at bedtime # 90 unf
Risperdal		1 mg	1 pill every morning and 2 pills at bedtime # 90 unf
Celexa		10 mg	1 pill twice daily

SOMA 724.4 296.44

799.9 564.00

Risks, benefits, and alternatives discussed? ☑ Yes ❑ No Explain: _____

OTHER RECOMMENDATIONS / INSTRUCTIONS

MRI 4/29/05

FOLLOW-UP APPOINTMENTS Include medical and non-medical appointments.
Patient or guardian has signed release of information for follow-up outside the Butler system? ❑ Yes ❑ No

MEDICAL	NON-MEDICAL
Name: Tony Allen, MD	Name:
Address: Shedai medical center	Address:
Tel#: bryan s samaria	Tel#:
Time & Date of Appt: May 16, 2005	Time & Date of Appt:
❑ Psychiatrist ❑ PCP ❑ other	❑ Psychotherapy ❑ other

Until you are seen by Dr. Allen (print name or program)

If you have any problems or questions about your condition or these medications, instructions or plans, please contact

Lisa Shea, MD (print name) at 5194614355-6206 (telephone)

These instructions have been reviewed with me* _____ (signature)

* ☑ patient ❑ parent ❑ guardian ❑ other _____

Comment if no signature: _____

4-18-05 (Date) _____ (Signature (s) (must be signed by physician if meds listed)) _____ (Print Name (s))

MR-13 (11-2002) **DISTRIBUTION: WHITE** - Chart **WHITE** - Customer Copy

TRANSFER/DISCHARGE SUMMARY PART I

107780
STEWART, ROXEANNE
226 PLEASANT STREET
PROVIDENCE, RI 08/08/1981
DR G. SURTI OUTSIDE BC
04/11/2005 ITU/ITP
3

Name
MR#

BUTLER HOSPITAL, Providence, Rhode Island

Date Admitted: 4/11/05

Date ☐ Transferred ☑ Discharged 4/22/05

FROM: AMA/Unplanned? ☐ yes ☐ no

Level of Care:

☑ acute inpatient ☐ residential inpatient
☐ observation bed ☐ partial hospital ☐ outpatient
☐ other

Program: ITU

Unit/Site:

Clinician: Surti

TO: ☐ No Further Treatment

Level of Care:

☐ acute inpatient ☐ residential inpatient
☐ observation bed ☑ partial hospital ☐ outpatient
☐ other

Program: ~~Dr Surti~~

Unit/Site:

Clinician:

DIAGNOSES PRINCIPAL: Psychosis NOS - 298.9

Axis I R/o Bipolar disorder 296.80
R/o Eating disorder NOS. 307.50

Axis II deferred 799.9

Axis III None active

Axis IV Deferred.

Axis V current 55-60 highest past year

IDENTIFYING INFORMATION AND REASON FOR TREATMENT

23 year old female, single, from Jamaica, RISD student admitted for disorganized and psychotic behavior.

SUMMARY OF CURRENT ASSESSMENT/TREATMENT Summarize response to medications, therapy, results of labs, consults, progress towards treatment goals.

Patient was originally [illegible], paranoid, inappropriate smiles, [illegible], ↓ intake, poor response to Zyprexa, started on Risperdal than Depakote added, fair response. more organized, not delusional, improved [illegible] & attention, more [illegible]. Multiple [illegible]

Last serum medication level: held with mother

CURRENT CONDITION/REASON FOR CHANGE IN LEVEL OF CARE Identify goals for further treatment or reason for ending treatment.

Affect Calm [illegible] [illegible] ∅ A/V Hallucination
∅ delusions. ∅ SI ∅ HI AxOx3

CURRENT RISKS Active problems which may affect clinical course. Describe all positives.

☐ yes ☑ no Active Medical Problems: None active
☐ yes ☑ no Medication Allergies: NKDA
☐ yes ☑ no Suicidal: ∅ SI ∅ HI
☐ yes ☑ no Dangerous:
☐ yes ☑ no Substance Abuse:
☐ yes ☑ no Other: (compliance/abuse/legal/social/cultural):

4/22/05 [signature] Surti
Date Signatures (s) Print Names(s)

MR 12 (Rev. 6-98 Kent) **DISTRIBUTION:** WHITE - Chart Copy, CANARY - CIS Copy

TRANSFER / DISCHARGE SUMMARY
PART II
PATIENT INSTRUCTIONS

BUTLER HOSPITAL
345 Blackstone Blvd.
Providence, Rhode Island

107780
STEWART, ROXEANNE
226 PLEASANT STREET
PROVIDENCE, RI 08/08/1981
DR G. SURTI OUTSIDE BC

Name: 04/11/2005 ITU/ITP
MR #: 3

MEDICATIONS To be completed by physician or designee, not valid unless signed below by physician.

Name of Medication ❑ No Medication Dose Times to be taken

Depakote 250mg PO 8AM & 500mg PO 8PM

~~Zyprexa~~ Error

Risperidal 1mg PO 8AM & 2mg PO QHS.

Attend Partial Hospital daily MONDAY — Friday 8:45AM - 3PM AT BUTLER HOSPITAL.

Risks, benefits, and alternatives discussed? ☑ Yes ❑ No Explain:

OTHER RECOMMENDATIONS / INSTRUCTIONS

If feel unsafe or Suicidal Call MD or return to hospital

FOLLOW-UP APPOINTMENTS Include medical and non-medical appointments.
Patient or guardian has signed release of information for follow-up outside the Butler system? ❑ Yes ❑ No

MEDICAL

Name:
Address:
Tel#:
Time & Date of Appt:
❑ Psychiatrist ❑ PCP ❑ other

NON-MEDICAL

Name:
Address:
Tel#:
Time & Date of Appt:
❑ Psychotherapy ❑ other

Until you are seen by
print name or program

If you have any problems or questions about your condition or these medications, instructions or plans, please contact

Dr Surti at 455-6365
print name telephone

These instructions have been reviewed with me*
signature

* ❑ patient ❑ parent ❑ guardian ❑ other

Comment if no signature:

4/22/05 Surti Surti
Date Signature (s) (must be signed by physician if meds listed) Print Name (s)

MR-13 (11-2002) **DISTRIBUTION: WHITE** - Chart **WHITE** - Customer Copy

Gmail **RoxStew5 . <rstewart.micopr@gmail.com>**

Release of Hospital Medical Records Copies

3 messages

RoxStew5 . <rstewart.micopr@gmail.com> Sat, May 20, 2017 at 10:10 AM
To: frank.knight@cwjamaica.com

Hello Dr. Knight, I hope you are doing well. There seems to have been a misunderstanding when my mother, Dr. Marcia Stewart, met with you to make known my request for copies of my medical records at Medical Associates Hospital. I am not asking for a report or a summary of my April 2015 hospitalization.

I, Roxanne Stewart (married name now Johnson), am asking you to give Medical Associates Hospital permission to release copies of the **existing medical records on file during my April 2015 hospitalization.**

When speaking to the hospital directly to have copies of these records released to me, they informed me that they needed your permission to release copies of the records before they could do so. I am simply asking for **copies of the medical records on file** during my April 2015 hospitalization. A report or summary will not be needed.

I appreciate your assistance,
Thank you

--
Roxanne Johnson,
Presenter / Voice Talent / Writer / Producer,
322-1182
www.facebook.com/roxannejohnsonmedia

Frank Knight <frank.knight@cwjamaica.com> Mon, Jun 12, 2017 at 8:55 PM
To: "RoxStew5 ." <rstewart.micopr@gmail.com>

Thank you for your email.

It seems Medical Associates does not have a record of the 2015 admission that they can find. But I have located my own notes and will provide your mother with a report based on them.

I hope all goes well with you

Regards,

Frank Knight.
[Quoted text hidden]

RoxStew5 . <rstewart.micopr@gmail.com> Tue, Jun 13, 2017 at 1:23 AM
To: Frank Knight <frank.knight@cwjamaica.com>

Thank you Dr. Knight, but that won't be necessary.

Thanks again,
[Quoted text hidden]

MEDICAL ASSOCIATES HOSPITAL
NURSING RECORD

DATE AND TIME	REMARKS
3/6/15 Cont'd	boyfriend's house as she did not feel safe. This am, while walking, she decided that she can no longer manage on her own so she was taken to AAE. Medicated & hospitalized for safety and stabilization. Admitted for management PMH - Nil PSH - Nil Drug Hx - Depacote, Seroquel Allergies - Social Hx - Smoke Drink O/A Young looking female. Very tearful and appears depressed. MSE Patient not boisterous in appropriately dressed for climate. Signs of paranoia noted as patient believes Nurse is trying to accuse her of lying about her condition. Patient shows signs of visual hallucinations. Insight fair as patient knows she needs help. No suicidal or homicidal ideations noted. O/A Drowsy female breathing freely on room air chest expansions equal and adequate. MM pink and moist. Perfusion adequate centrally and peripherally. Abdomen soft and non-tender. Voids spontaneously. Full movement and sensation present. Skin

NAME: Roxane Stewart DOCTOR: Knight ROOM: 109

W - Witheld as Ordered, R - Refused
U - Patient unable to take Medication, S - Stock

MEDICAL ASSOCIATES HOSPITAL
PROGRESS NOTES

STATE

Sat Apr 04 Seen 8:15 a.m.

Doing: But can rouse enough to make full contact

Nurses report she declined Seroquel yesterday as she said it [redacted] has caused her in the past to have hallucinations. So it has b

She speaks clearly + has reasonable insight. Recalls the yesterday her friend seemed to be acting strangely. Reports she has no hallucinations since (A?), but only "illusions" (she has the concept correct! eg. cell phones + g/c seemed to be louder. But also she did at one point hear a baby's crying). Inquires what her IM inj yesterday was.

HR BP has been low (90/60 at 6 am)

Assess: Improved.

Plan: 11/4 Switch to CPZ 100 + bid (from Seroquel)

7KNIGHT

DOCTOR: Knight ROOM: 109

STEWART

MEDICAL ASSOCIATES HOSPITAL
PROGRESS NOTES

DATE AND TIME	
2015 Sun Apr 05 Mon Apr 06	Seen 7:15 am (Had just come back from an outside stroll with her Niece) Fully clothed. Fully in touch. Reluctant to agree to home Secroquel Plan: 1 Risperidal 4 mg tds 7KNIGHT
Tue Apr 07	Seen 6:45 pm Clinically she is ready ready to leave hospital. I have left a message for Dr Earl Wright who will be taking over Ms Stewart's care and arranging for her discharge. I will inform the Hospital when the transfer takes place. Plan Keep on regime 7KNIGHT

NAME: Ms Roxanne STEWART
DOCTOR: F Knight
ROOM: 109.

W - Withheld as Ordered, R - Refused, PNTD - Patient not in [illegible]
U - Patient unable to take Medication, S - Stock

MEDICAL ASSOCIATES HOSPITAL

NURSING RECORD

DATE AND TIME	REMARKS
6/4/15	if she doesn't have a problem with the [illegible] regime and if she doesn't have a problem with not being informed of the [illegible] regime. She said "yes" but she [illegible] the discussion beyond the "yes", the [illegible] — [illegible]
2-3³⁰ pm	Patient ambulating along corridor and down staircase with nurse and "[illegible]" — [illegible]
4⁰⁰ pm	[illegible] in room with [illegible] parent — [illegible]
5³⁰ pm	Tolerating [illegible] of diet
08.04.2015 8pm	Received patient in bed. Nil distress observed. Voiced no complaints. MSE: Alert and rational. Calm. Affect congruent ē mood. Appropriately attired. Denies hallucinations, suicidal or homicidal ideations. Nil paranoia observed at this time. Judgment good. Thought process good. Insight to illness fair. Long and short term memory intact. Physical assessment unremarkable. — [illegible]
	Plan: Monitor v/s. Medicate as ordered. [illegible] and comfort [illegible] when awake. Ensure safety. [illegible]
	Private nurse present. — [illegible]
09.04.2015 2³⁰ pm	Tolerated water — [illegible]
9⁰⁰ pm	v/s T 97 P 96 R 20 BP 100/70 — [illegible]
10.04.2015 9³⁰ pm	Patient asleep in bed. Nil distress observed. [illegible]
11pm	Patient was asleep in bed. — [illegible]
[illegible].04.2015 12 MN	Patient remained asleep in bed. Private nurse present. [illegible]
12-2am	Patient was still asleep. Nil distress noted — [illegible]

NAME: Roxanne Stewart DOCTOR: Knight ROOM: 109

W - Witheld as Ordered, R - Refused, P[illegible]

U - Patient unable to take Medication, S - Stock

MEDICAL ASSOCIATES HOSPITAL
PROGRESS NOTES

DATE AND TIME	
2015 Sun Apr 05 Mon Apr 06	Seen 7:15 am (Had just come back from an outside stroll with her Niece) Fully clothed. Fully in touch. Reluctant to agree to home Secroquel Plan: 1 Risperidal 4 mg tds 7KNIGHT
Tue Apr 07	Seen 6:45 pm Clinically she is ready ready to leave hospital. I have left a message for Dr Earl Wright who will be taking over Ms Stewart's care and arranging for her discharge. I will inform the Hospital when the transfer takes place. Plan Keep on regime 7KNIGHT

NAME: Ms Roxanne STEWART
DOCTOR: F Knight
ROOM: 109.

W - Withheld as Ordered, R - Refused, PNTD - Patient not in [illegible]
U - Patient unable to take Medication, S - Stock

MEDICAL ASSOCIATES HOSPITAL

NURSING RECORD

DATE AND TIME	REMARKS
	Cont
7.4.15	That he is not informing her of changes in medication
	and that she is on antipsychotic Risperidone and
	in makes her hallucinate state she stated she [illegible] an
	empty box that appear like earphones [illegible]
5.30pm	Tolerated supper remains calm [illegible]
6pm	Medicated c̄ Risperidone 3mg, Lithium [illegible], [illegible]
	2mg [illegible]
7pm	Reviewed by Dr Knight no changes in mx
	Stable care continues [illegible]
8pm	Patient received awake and alert, nil
	immediate Distress Patient verbalized
7th/April/2015	Visual Hallucination MSE: Affect flat mood
	incongruent with expressed affect, Affect appropriate
	nil homicidal or suicidal ideations patient
	cooperative and pleasant. O/E Pupils [illegible]
	Reactive, chest expansion equal adequately, Abdomen
	Soft non-tender, bowel sounds active movement
	and sensation to all limbs. Plan of care [illegible]
	① Meds as prescribed ② Ensure safety ③ [illegible]
	⑤ Provide psychological support [illegible]
97.0 96[illegible] 10pm	V/S T 97.2 P [illegible] [illegible] BP [illegible]
7th/April/2015 10pm	Medicated as prescribed by physician [illegible]
10pm–12MN	Patient Asleep nil distress [illegible]
12MN–2AM	Patient Asleep nil change [illegible]
2AM–4AM	Patient Asleep nil change [illegible]
6AM	Medicated as prescribed [illegible]

NAME: Roxanne Stewart DOCTOR: Knight ROOM: 19

W - Witheld as Ordered, R - Refused, [illegible]
U - Patient unable to take Medication, S - Stock

MEDICAL ASSOCIATES HOSPITAL

NURSING RECORD

DATE AND TIME	REMARKS
09.04.2015 Cont'd	Thought process good. Judgement good. Long and short
	term memory intact. Fair insight to illness. Denies any
	hallucinations, homicidal or suicidal ideations.
	N/A to physical assessment. Plan: Medicate as
	ordered. Monitor v/s. Monitor MSE. Ensure safety.
	Psychological support. ——— [illegible] RN
09.04.2015 9pm	Patient settled to sleep. v/s T 96.4 P 58 R [illegible] BP 100/60
	Private nurse present. ——— [illegible] RN
09.04.2015 10pm	Patient was seen asleep in bed. Rails up for safety. [illegible]
10-12mn	Patient was asleep in bed. Nil distress was observed. [illegible]
10.04.2015 12-2am	Remained asleep throughout. ——— [illegible]
8:30 am	Patient is now awake. Stated it was too early. Requested
	water. Same given. ——— [illegible]
10.04.2015	Returned to bed ——— [illegible]
5:30 am	Had hygienic needs met. ——— [illegible]
10.04.2015 6:00 am	v/s T 96 P 88 R 24 BP 160/100 SpO_2 98% [illegible]
	Medicated as ordered c̄ lithium 50mg po, cogentin 2mg
	po and risperidone 3mg po. ——— [illegible]
10.04.2015 7:00 am	Left patient sitting out of bed. Fair shift spent.
	For home today. Dr. will not come to review. Care
	continues. ——— [illegible]
10.04.15 8:00	Received patient lying in bed breathing
	freely on roomair. Pale pink peripherally
	and centrally. Chest expansion equal
	and adequate. Chest clear. Abdomen
	obese. NAD to Extremities. Affect flat,

NAME: Roxanne Stewart DOCTOR: Knight ROOM: 109

Witheld as Ordered, R - Refused, PNID - Patient Not in Department, [illegible]
Patient unable to take Medication, S - Stock