

2004

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Citation Information

Patton, Lora M.. "Providing Services to Clients with Serious Mental Illness: New Challenges and Opportunities for Community Legal Clinics." *Journal of Law and Social Policy* 19. (2004): 18-31.
<https://digitalcommons.osgoode.yorku.ca/jlsp/vol19/iss1/2>

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PROVIDING SERVICES TO CLIENTS WITH SERIOUS MENTAL ILLNESS: NEW CHALLENGES AND OPPORTUNITIES FOR COMMUNITY LEGAL CLINICS

LORA M. PATTON*

RÉSUMÉ

Le Bureau de l'intervention en faveur des patients des établissements psychiatriques est un programme autonome du ministère de la Santé et des Soins de longue durée. Il vise à offrir des conseils juridiques dans la plupart des établissements de la province régis par la Loi sur la santé mentale. Des défenseurs des droits des patients indépendants opèrent à partir de chacun des 10 établissements psychiatriques anciennement ou présentement gérés par la province.

Le retranchement des hôpitaux psychiatriques provinciaux et la désinstitutionnalisation ont amené une nette augmentation du nombre d'insertion dans la collectivité de personnes souffrant de maladies mentales graves. On a fermé les grands établissements et les gens sont maintenant traités par le biais de solutions de rechange tel que les Équipes de suivi intensif dans la communauté, les Ordonnance de traitement en milieu communautaire et les Congés autorisés. En d'autres mots, des personnes souffrant de maladies mentales graves se retrouvent maintenant dans la collectivité bien plus souvent.

Ce changement confronte les cliniques juridiques communautaires à un certain nombre de défis. L'article examine trois domaines principaux qui sont à la fois nouveaux et posent problème pour les cliniques : de nouveaux types de clients (ceux souffrant de maladies mentales graves) ayant des préoccupations juridiques touchant aux domaines traditionnels des cliniques; des clients ayant des problèmes similaires à ceux que nous traitons typiquement dans les cliniques mais avec une tournure toute particulière liée à leur maladie; et finalement, des problèmes totalement nouveaux, ayant trait aux engagements que la personne en question a eu avec le système de santé mentale.

Qui dit nouveaux clients, dit nouveaux défis. Des personnes avec des maladies mentales graves peuvent ne pas être capables d'identifier des problèmes juridiques, et cela pour plusieurs raisons possible : à cause du manque d'accès à de l'information juridique; du fait de n'avoir pas vécu de façon autonome par le passé et à cause de l'effet de l'« institutionnalisation », ou l'acceptation de l'autorité. En plus, les personnes

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souffrant de maladies mentales graves peuvent aussi trouver de la difficulté à expliquer leur problème. Cette difficulté peut découler des symptômes-mêmes de la maladie, des effets secondaires des médicaments, d'un manque de confiance, ou de toute une série d'autres problèmes. Dans le but de satisfaire aux besoins en matière de communication de ces nouveaux clients, les cliniques peuvent prendre un certain nombre d'initiatives : organiser des opérations de vulgarisation, axées sur cette clientèle, par le biais de programmes de formation juridique du public; lancer des sessions de formation sur les différents types de maladies mentales et des adaptations nécessaires; et, développer de nouvelles méthodes de communication (capacité d'écoute, bâtir des relations de confiance et bien comprendre les limites).

Les clients souffrant de maladies mentales graves peuvent très bien se trouver dans des situations similaires à celles d'autres clients de la clinique, mais avec en plus, des dimensions toutes nouvelles à ces problèmes. Ainsi, dans le cas d'un cas d'appel concernant un handicap POSPH, l'affaire pourrait être compliquée par le fait que le client était convaincu qu'il pouvait travailler. Il peut aussi y avoir des cas d'éviction de locataire où le motif pour l'éviction se trouve être précisément la maladie mentale grave (par exemple, une personne dans un logement subventionné qui fait face à une Demande de cessation d'effet à cause de réparations et d'entrave à la jouissance raisonnable). Encore une fois, cela requiert le développement de nouvelles aptitudes à communiquer, ainsi que le développement de nouveaux arguments juridiques (basés, par exemple, sur la législation des droits de la personne). Ces clients pourraient avoir besoin de nouveaux types de solutions pour des problèmes similaires.

Et, en dernier lieu, des clients avec des maladies mentales graves, pourraient se trouver dans des problèmes de types totalement nouveaux. Ils peuvent avoir besoin de procurations pour soins personnels ou soins de leurs finances. Il se pourrait qu'ils aient à contester des Ordonnances de traitement en milieu communautaire qui auraient pour portée de leur enlever d'autres droits légaux. Il se pourrait aussi qu'ils aient à faire face à des atteintes aux droits de la personne, tel que la séquestration et les mauvais traitements. Il y a présentement un vide dans les services juridiques pour des problèmes de ce genre. Pour s'en prendre à ces nouveaux problèmes, la clinique aura peut être à oeuvrer à l'intérieur de nouveaux régimes législatifs, à essayer des arguments juridiques nouveaux, à développer et faire avancer encore plus de causes types, à faire moins usage de plaidoiries traditionnelles, et à s'employer à la réforme du droit.

Pour conclure, alors que de plus en plus de personnes atteintes de maladies mentales réintègrent la collectivité, cela annonce un rôle tout nouveau et tout passionnant pour les cliniques juridiques communautaires. Travailler avec des personnes atteintes de maladies mentales graves est enrichissant. Cela ouvre la porte à de nouveaux défis, à la fois dans les domaines traditionnels de services juridiques pour les personnes à faible revenus, et dans les nouveaux domaines de promotion et protection des droits de la personne.

At the Connection and Directions Conference, held in Hamilton in July 2003, I spoke about the gaps in legal services for persons who live with mental illness. I suggested that legal clinics explore how we can more effectively meet the needs of this client group through education, outreach, and direct file work. This paper is based on that presentation as well as my more recent experience in building a mental health division in a student legal aid society. I hope that the practical aspects of this paper will provide a basis for initiating positive conversations in community legal clinics about how to best provide comprehensive service to this client group.

Sweeping changes are underway in Ontario's mental health system. Once primarily endorsing institutionally based systems, isolating persons with serious mental illness (SMI) in 10 provincial psychiatric facilities across the province, successive governments have endorsed a community-based mental health policy, reintegrating persons with SMI into their communities, allowing them to receive care and treatment closer to their homes and support networks. The transition has not been seamless, however. The availability of community services has not kept pace with demand. Many persons have been left without necessary supports, and many persons with SMI are struggling to live with limited affordable housing and on minimal incomes. Discrimination and stigma continue to affect their ability to find appropriate work, services, and homes, and poverty remains a significant factor in the lives of many.¹

Community legal clinics are seeing an increasing number of persons with SMI in their waiting rooms² who have the same issues as those who face the more traditional client base. However, despite the growing number of such clients, the clinic system has not, as a whole, developed a strategy for effective advocacy. While excellent services for persons with SMI are available through specialty clinics, such programs are available only for persons who meet additional criteria.³ Those who fall outside of specialty

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1. Studies indicate a complicated relationship between poverty and mental illness with both direct and indirect links. (See Health Canada *A Report on Mental Illness in Canada*, 2002 found at <http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/miic-mmacc/chap_1_e.html>.)
 2. While no statistics are available on the numbers of persons with serious mental illness who are accessing or may want to access community legal clinics, general information demonstrates that the numbers of persons in the community without adequate supports have increased. A study by Kathleen Hartford and Lisa Heslop (*Trends in Police Contact with Persons with Serious Mental Illness in London, Ontario* [London: University of Western Ontario and Lawson Health Research Institute, 2002]) notes that between 1998 and 2001, police contact with persons with mental illness increased 25%. The report also notes that the number of hours spent by police on such issues doubled over the same period. The Ontario Association for Police Chiefs has passed a resolution seeking a broader study to determine the numbers across the province. While police involvement is not directly analogous to clinic services, the statistics make clear that significantly more persons with serious mental illness are in the community.
 3. Both the Advocacy Centre for the Elderly and the Homelessness Project out of Neighbourhood Legal Services work in the area of mental health law; however, the nature of their mandates (to serve the elderly and the homeless of Toronto, respectively) establishes services for only a small

clinic mandates receive varying levels of service, depending on their geographical catchment area and the expertise within their local clinic.

Without a general strategy, clinics continue to work with persons with SMI without recognizing and accommodating their special needs. Some caseworkers feel inadequately prepared to manage the unique issues that arise from working with clients with SMI and, as a result, shy away from such cases or minimize retainers. Rarely do clinics address issues that may affect this group specifically as a result of the combination of their poverty and vulnerability, leaving a gap in the different services offered.

As front-line workers (experts in legal issues affecting low-income persons and a primary source of legal information and education in communities), lawyers, and staff in community legal clinics are uniquely situated to provide comprehensive service to persons with SMI. We cannot, however, simply apply traditional skills and knowledge to this unique group of clients; rather than providing the same services in the same way, we need to identify the unique needs of this client group and accommodate those needs. This response will require continuous learning, the sharing of information and best practices, and partnering with traditional community mental health agencies, consumer-survivors, and advocacy organizations in skills development and training. Such partnerships will only strengthen the work of the clinics and access to justice for this client group.

Community clinics are beginning conversations about how to effectively serve this client group and how to tackle internal processes that fail to address new challenges. I hope to build on these initial discussions and will, below, identify three primary means of focusing services for persons with SMI:

- Reviewing and improving current processes (providing traditional services to a new client group)
- Integrating mental illness, the law, and poverty (providing traditional services with a mental health component)
- Discovering service gaps and providing non-traditional services

IMPROVING CURRENT PROCESSES

As community clinics have already discovered, persons with SMI living in the community tend to experience many of the same difficulties experienced by other traditional client groups: finding safe, decent, affordable housing; securing and maintaining sufficient income through employment or government assistance; securing status through the immigration or refugee process; obtaining and sustaining meaningful employment; and dealing with discrimination. Many clinics are already providing services to persons with SMI simply by default – clients come to the clinic for the areas of law it provides service in, and the mental health issue is incidental. Instead of simply serving through default,

clinics can develop their own skills, appropriate policies, and development plans to specifically target and provide effective service to this client group.

Staff Education

Before a clinic can begin to expand and develop its services to persons with SMI, staff at the clinic must be educated. Fundamentally, the clinic must create an environment in which staff members can comfortably articulate their concerns and fears in dealing with persons with mental illness. In the legal profession generally, including the progressive, inclusive environments of legal clinics, stigma follows clients with mental illness. As described by Michael Perlin, a clinical law professor at New York Law School, discrimination on the basis of mental illness or “sanism” “is as insidious as other ‘isms’ and is, in some ways, more troubling, since it is (1) largely invisible, (2) largely socially acceptable, and (3) frequently practiced (consciously and unconsciously) by individuals who regularly take ‘liberal’ or ‘progressive’ positions decrying similar biases and prejudices that involve sex, race, ethnicity and/or sexual orientation.”⁴ Clinic case-workers are not immune to discriminatory beliefs and practices that influence whether they seek out clients with mental illness and their work with such clients.

Professor Perlin outlines some of the myths about mental illness and persons with mental illness upon which law students (like other legal workers) form opinions and provide service, some of which I have included below:

- Persons with mental illness are incompetent to engage in autonomous decision making, including decisions about health care, choice of trial strategy, and external “life decisions”
- The mentally ill can be dangerous, so clear evidence to the contrary should be rejected
- Quality of life for such people (housing, family, job satisfaction) is less important than for normal people
- Information about a client that does not conform to an image of mental illness should be rejected (the client works in a professional field, is highly educated, or came from a middle-class background)⁵

The pervasiveness of such beliefs throughout the legal arena and legal clinics necessitates a commitment to anti-discrimination and stigma education, preferably with strong influence from consumer/survivor groups within the community. Involving persons with SMI in training allows staff to meet individuals who have had experience in the psychiatric system and, most likely, with legal services. The idea of a “mental health client” may be demystified and caseworker’s fears mostly alleviated.

4. Michael L. Perlin, “You Have Discussed Lepers and Crooks: Sanism in Clinical Teaching” (2003) 9 *Clin. L. Rev.* 683 at 704.

5. *Ibid.* at 722–24.

Basic information about the types of mental illness, symptoms, and ways to best accommodate the needs of such clients may further help caseworkers appreciate the situations their clients face. A very simple example is that of the client whose medication for bipolar disorder (manic depression) causes significant morning fatigue. Understanding that will allow a caseworker to arrange telephone calls, appointments, and appearance dates in the late afternoon.

As a result of the prevalence of sanism, clinic staff may feel overwhelmed by the perceived difficulties in interviewing and working with clients with SMI. With little education about mental illness, many staff members feel unprepared. Skills development in interviewing, information gathering, listening skills, and examinations may also be of tremendous benefit, particularly if they involve problem solving in difficult situations. For example, caseworkers can benefit from role-playing scenarios where a client is unable to focus on the task at hand or wants the clinic to take inappropriate steps for what appears to be a delusional belief of persecution.⁶

Finally, specific education on legislation that affects clients with SMI may be extremely important. For example, understanding the general principles of the *Mental Health Act* about involuntary detention in hospital may be fundamental in a caseworker's ability to assist a detained client in maintaining housing or income support. The *Substitute Decisions Act* will help to understand a client's relationship with the Public Guardian and Trustee and his or her ability to pay for services.

Policies provide the basic groundwork for caseworkers to apply in unusual or difficult situations and can also act as a tremendous education tool. Policy development in this area can be very broad, but a number of issues should be resolved at the outset to provide guidance:

- Non-discrimination policies should be revised as necessary to clearly include mental illness.
- Safety policies should be implemented to protect staff and clients.⁷

6. I hesitated to use this example, as I did not want to suggest that those who live with delusions should be dismissed or that the existence of an apparent delusion should influence a caseworker's perception of other articulated concerns (a client could complain of the CIA putting pressure on the landlord to evict, but persecutory belief does not lessen the fact that this client may be at risk of an eviction). I ultimately decided that the occurrence of such issues in clinics necessitated its mention and hope that frank discussions will happen in clinics about how to conduct interviews in such cases.

7. While it would be inappropriate to dwell on safety concerns, given that the risk of violence is no greater in this client group than the broader population, policies are necessary to deal with the minority of possible situations. Such policies should be implemented for all persons, not simply clients with mental illness, for the protection of both staff and clients. Further, discussions around these issues are invaluable for educational purposes.

- Clear policies about confidentiality and the basis for breaching confidentiality should be developed, with clear reference to Law Society rules, caselaw, and relevant legislation.⁸
- Clients should have access to their own files and be informed of this access, and that change may quell discomfort (many clients will have had professionals writing information in their clinical records, and that “secret” information can be discomforting).
- Guidelines on a client's capacity to instruct should be discussed for possible inclusion in policy, with appropriate steps outlined for what should happen if the clinic determines that a client is incapable.⁹
- Best practices surrounding the appropriate scope of retainer and policies around appropriate termination of retainers should be developed and properly communicated to clients at the outset of a file.

Policies serve a number of purposes in addition to providing guidance. Development may initiate staff discussion about difficult issues, educate about rules of conduct and professional responsibility, and inform clients about what they can expect at the clinic.

While the amount of education and development seems overwhelming, a number of free or inexpensive options are available to increase education. Clinics can look within to determine what types of resources are necessary, based on their experience and pre-existing knowledge of mental health issues. Conducting workshops, bringing in speakers as part of an annual general meeting, or engaging in more formal continuing education can all add a level of security to staff members. In larger centres, more specialized resources may be available, allowing education on more advanced subjects, such as cultural issues relating to mental illness, or how it affects certain groups, such as the elderly.

The clinic system also has a number of internal resources available for broad education initiatives and policy support. Some individual clinics, including specialty ones, already have experience in working with clients with SMI. Clinic staff with background knowledge and experience could lead local, regional, or provincial workshops. There are a number of other resources in the community as well: consumer organizations are often willing to work with groups to provide education, and consumer involvement can only enhance the education experience.

8. See *Smith v. Jones*, [1999] 1 S.C.R. 455, and LSUC Rules of Professional Conduct 2.03, particularly 2.03(3).

9. See LSUC Rules of Professional Conduct, 2.02(6) Client under a Disability, 2.02(2) Encouraging Settlement/Discouraging Commencement of Useless Proceedings, and 2.09 Withdrawal from Representation. There is also some guidance for capacity to instruct counsel in the criminal context: *R. v. Taylor* (1992), 77 C.C.C. (3d) 551; Reference *Re: R. v. Gorecki* (No. 1) (1976) 32 C.C.C. (2nd) 129, and *R. v. Swain*, [1991] 1 S.C.R. 933.

Some people in clinics are also reviewing the possible creation of a working group specifically in the area of mental health. While the group could be given responsibility for education, it may also be used as a panel of “experts” who can develop draft sample policies and guidelines and examine difficult issues relating to practice in this area.

Creating Client-Friendly Environments

Once staff and caseworkers are comfortable with their knowledge and skill level, attention must be directed to barriers in the clinic environment that may discourage or prevent clients with SMI from feeling comfortable. Additionally, addressing physical plant issues can also dramatically increase staff feelings of comfort and safety.¹⁰

The first contact a client or a potential client will have with the clinic is generally the receptionist. Such contact may occur by phone or walk-in, but often the process is much more complex than simply scheduling appointments for caseworkers. Reception and other administrative staff must receive training in mental health similar to that given others in the clinic, to ensure that they have the skills necessary to negotiate difficult conversations or requests appropriately. Often the person answering the phone will be the only one available should a crisis arise. Training on community referrals such as crisis lines, consumer/survivor-friendly centres, shelters, and other resources are essential for everyone, but in particular for front-line staff. Having this information available quickly will also reassure clients.

The design of the reception and interview areas is not easily changed to accommodate client needs, although it can be considered when redesigning or moving to a new space. Larger spaces are often reported to be more comfortable for clients as is the absence of “clinically” bare walls. Glass inserts in doors prevent claustrophobia and also allow other workers to monitor any difficult situations. Policies requiring more than one staff member to be in the office area during client meetings can make both client and caseworker more comfortable. Clients should be queried about their comfort level, and accommodations can be individualized as necessary.

The easiest way to collect input on obstacles in the office is to involve consumer/survivors in the review – perhaps as members of a working committee on the board or a more informal group to make suggestions. Many of the resulting changes, particularly those pertaining to safety, will have a much broader application than only for clients with mental illness and may greatly enhance the office environment.

Such environmental issues go beyond obvious physical factors, however, and a very open review of general clinic processes must also occur with a view to accessibility for all populations. Internal processes and procedures may as easily create barriers to access as a clinic's physical design.

10. Persons with mental illness are 2.5 times more likely to be victims of violence than are the general population and are not more likely than the general population to harm others. See Canadian Mental Health Association fact sheet online: http://www.cmha.ca/english/info_centre/mh_pamphlets/mh_pamphlet_vmi.htm.

Simple process changes may alleviate a client's discomfort with the clinic; for example, if intake occurs only during morning hours, such scheduling may not take into account persons who are on potent medications that prevent them from functioning well early in the day. While morning intake may be a minor consideration for clinic staff, shifting it to the afternoons, at least on some days, may make it more accessible for clients. Sensitivity to the length of time any client spends in the waiting room is important, particularly so with this client group. Conducting intake only at the clinic may not reach the client base, for potential clients may not have sufficient funds for transportation or may not feel comfortable travelling to an unknown location for assistance. Formal satellite offices with partner agencies, informal drop-in services, or arrangements to meet clients off-site may also be appropriate.

Process barriers may be more difficult to manage at student legal aid societies. At the Community and Legal Aid Services Programme (CLASP), we have noted a number of potential difficulties in working with persons with SMI, three of which illustrate the need for accommodation: (1) student volunteers who have less training than the full-time student program participants receive initial requests for services and conduct intake interviews; (2) the clinic closes for intake twice yearly for exams, and caseworkers are less available; (3) and there is caseworker turnover at least yearly and perhaps more often, as new students become involved in the program. At CLASP, we are considering a number of mechanisms to overcome the challenges we have identified to date. It is possible, for example, that we will direct all intake for persons with SMI to students with more training. Counsel already bridges clinic intake closures; however, more active file work may be required for this client base. Finally, caseworker turnover can be minimized, and a clear connection to counsel, for continuity, may be required.

Accessing Clinic Services: Accessibility and Accommodation

In determining whether clients with SMI are being appropriately served by the clinic, a simple review of statistics may be very telling. Are clients with SMI coming to the clinic? If not, why not? We know that such clients are more likely to live in poverty than the general population, and we know that, as a result of their illness, they may be more vulnerable. If such clients are not seeking the services of the clinic, there may be additional barriers that prevent access. Once environmental factors at the clinic are resolved, clinics may also ask whether or not their community outreach and public education is effectively targeting this group.

While an intensive needs assessment would be an ideal tool for reviewing the numbers of persons in the community with SMI, determining their needs and planning services, such an assessment is labour intensive and has at least some administrative costs attached. While Legal Aid Ontario has indicated a need for such a full review,¹¹ until

11. Legal Aid Ontario has noted that mental health is a priority on a number of occasions (see Angela Longo, "Adapting To Suit Changing Client Needs: Beyond the Traditional Model of Access to Legal Aid" [Paper presented to the Law Society of Upper Canada, May 2003]). Ms. Longo also identified the need for a needs assessment in her remarks to the Connections and

funds become available, less formal determination of needs can be undertaken, which will provide a great deal of information to the clinic.

In most regions across the province there will be a hospital or service provider. Such caregivers are often linked with independent patient advocates or groups such as Patient Advocates,¹² patient councils,¹³ or informal social groups. These groups can provide valuable information about the needs of their communities, as they are often the first stop for individuals seeking information and referrals.

While it is preferable to go to the clients and their representatives for information, the hospitals themselves may also provide much information about community needs. In particular, outpatient units, assertive community treatment teams, and community treatment coordinators may have experience with a number of the issues experienced by their clients during the shift from hospital to the community.

Beyond the hospital, other target organizations may be able to provide information: community health clinics, government organizations such as Community Care Access Centres), family support groups, and others. Once initial contacts are made, additional referrals can be made, and contact lists may grow exponentially.

After determining the extent of the target client group and their general needs, clinics must determine how to get their message out and how to build relationships within this community. Traditional forms of outreach and education may fail to effectively target persons with SMI and meet their unique needs.

A primary challenge for clients who have spent significant periods of time in hospital is the idea of “institutionalization”. In hospital, clients are seldom encouraged to voice their concerns. They learn that insisting on rights may be punished as disruptive behaviour and that complaining itself may be “pathologized” as part of their illness. Where clients must survive in an environment completely controlled by others, they learn to make do, quietly accepting the rules that are imposed. Then once such clients return to the community, it is often difficult for them to relearn self-advocacy. Coupled with the same lack of rights-awareness consistent in other poor communities is the clients' vulnerability to authority figures like landlords and social assistance workers.

To engage these clients, clinics may have to take further steps in outreach to ensure that persons with SMI are aware of their rights, their ability to challenge unfair decisions or inappropriate conditions, and the availability of clinic services to assist them. Non-traditional outreach may be conducted to areas in which these potential clients are most likely to receive the information: rooming and boarding homes,

Directions Conference in Hamilton, May 2003.

12. The Psychiatric Patient Advocate Office, an arm's-length government organization, provides rights advice and professional advocacy services. It has locations in each of the 10 current and former provincial psychiatric hospitals.
13. The Ontario Coalition of Patients' Councils is a patient-directed organization and can be found in most hospitals.

community health centres, consumer/survivor networks, and mental health service providers. For the most effective outreach and education initiative, consumers/survivors can be asked to participate in clinic planning through membership in the boards of clinics or on advisory committees.

INTEGRATING MENTAL ILLNESS AND POVERTY

Once clinic workers are comfortable with providing services to persons with SMI and clients are comfortable with the clinic, casework and systemic reform can focus in a renewed way on the intersections of poverty and mental illness. Often, new tools are necessary to provide effective representation to persons with SMI. To illustrate such needs, I have outlined some examples of cases below in which clients with SMI presented with fairly typical issues. After the examples, I will discuss the unique issues around process, outcome, and systemic opportunities that may arise through representation.

Client A: A client has applied for ODSP at the urging of Ontario Works. He agrees that he wants the pension because he needs the extra money he would receive but believes that he could work in a number of high-level positions including law, accounting, and medicine, despite his lack of formal training. He is unwilling to state that he is unable to work despite a long history of unemployment that is a result of his mental illness.

Client B: A client has received a first eviction notice for interfering with the reasonable enjoyment of the other tenants in the unit. She periodically will speak loudly to herself both inside her apartment and in the common and outside areas. The noise can be very loud at night when other tenants are trying to sleep, and because her behaviour is unusual, it can be disconcerting for some. The landlord has received complaints from the other tenants and is concerned that they will vacate the apartments as a result of the disruption.

Client A's goal, to obtain Ontario Disability benefits, is consistent with the process undertaken by clinics routinely. Traditional practice would then leave the means of accomplishing that goal to the caseworker, who will plan and execute the strategy for a hearing. In this case, however, divorcing process from the client's goal would potentially jeopardize his ability to receive the benefits because he refused to give evidence consistent with the caseworker's theory and may, in fact, withdraw his application if pushed. New skills relevant to client interviewing, counselling, and building trust may be employed and may be successful in convincing this client of the ultimate good in proceeding in a particular direction. Should these attempts fail, however, caseworkers must be cautious about giving ultimatums or inappropriately terminating retainers. Rather, a caseworker may have to consider alternative strategies for the hearing that are consistent with the client's concerns: perhaps proceeding without the evidence of the client and using medical documentation and other witnesses, eliminating questions relating to ability to work, and others. Flexibility of process is key in these situations¹⁴ and should involve the client whenever possible.

14. The intersection of client autonomy and capacity is much too broad to deal with in this discussion. I have assumed in this example that the client is capable of making decisions about his or

Determining what result a client actually seeks is key to any solicitor–client relationship, and determining the goals for clients with SMI is perhaps more important, because the best result may not be traditional. Client B faces possible eviction because of behaviour associated with her mental illness. A typical goal would be simply to prevent the eviction – which is key and is not necessarily a given in the current housing environment. Clinics have successfully incorporated the provisions of the *Human Rights Code* into Tribunal and court decisions, requiring recognition of the landlord's duty to accommodate.

The successful defence of the eviction may assist Client B only temporarily. She will continue to exhibit signs of her mental illness and will, undoubtedly, continue to clash with neighbours as a consequence. Future eviction attempts may follow, resulting in ongoing housing instability for this client. Of course, care must be taken not to impose the caseworker's own notion of the client's "best interest" with his capable decision, even where such a decision is contrary to advice; however, there is also an obligation to discuss the multitude of options available to a client in such situations.

A caseworker may look outside the traditional contingent of results for clients with SMI and look at broader solutions for the problem. In a chapter that I once read as part of clinical law training,¹⁵ the author discussed the legal worker's "over-definition" of problems and the well-intended narrowing of matters into appropriate legal boxes. In a case of tenancy arrears, the author encouraged new interviewers to forgo the immediate classification of a problem as an eviction problem with remedy at a Tribunal and to see the broader picture: the person does not have enough money to pay the rent, he may need better income, he may need social assistance, he may need cheaper housing, and so on. The range of solutions should be as broad as the problem definition, and part of the goal of a caseworker is to ensure that the problem is properly defined by soliciting that information from the client after properly informing him or her of all options. While, as the author notes, we cannot build clients houses, we may be able to accomplish a number of other solutions. In the case of Client B, her goals in the legal process may be quite different from a simple eviction defence: she may want more supportive housing, community mediation services may resolve some of the conflict with her neighbours, or an anti-stigma mental-health information session may be planned for the building complex. The most effective caseworkers will consider and accept or reject a number of creative solutions.

DISCOVERING SERVICE GAPS AND PROVIDING NON-TRADITIONAL SERVICES

As clinics provide more services for persons with SMI, gaps in services between traditional clinic areas and those covered by the private bar will become all too evident.

her legal position, and on the facts presented, likely is. Clinic discussions about client capacity should explore the issue of capable decisions that are contrary to advice.

15. K.F. Hegland, *Trial and Practice Skills in a Nutshell* (St. Paul, Minn.: A. Thompson, 2002) at 13–29.

Clinics may consider taking on a broader range of services to effectively assist persons with SMI in individual advocacy areas as well as law reform.

Some service gaps already noted by clinics are within their current mandates, although outside the most traditional areas of expertise. Broadening the scope of matters dealt with by the clinic may be necessary to assist clients with SMI in basic legal issues: housing, social assistance, and others. One clinic,¹⁶ for example, has partnered with a number of community organizations to create and implement a bill of rights for residents within domiciliary hostels – housing is clearly an issue within the broader scope of clinic services, and clinics were able to lend their legal expertise to drawing up the bill, although the type of issue (domiciliary hostels) was atypical as was the goal of creating the bill. The coalition also allowed the clinic to build a stronger relationship with consumer groups and other community-based organizations and ensured that a group of potential clients that previously did not use their services began approaching the clinic for tenancy matters.

Some services that clinics may want to consider are matters not presently dealt with to any degree by their offices. One such needed service is the preparation of powers of attorney, for both property and personal care. A legal aid certificate does not generally cover powers of attorney, but few clinics have the expertise to provide expert advice and assistance for the specialized client group who receive psychiatric services. Nor would it make practical sense in all cases for clinics to develop this expertise; rather, a partnership with a private bar mental health lawyer who can provide these services in an “advice clinic” periodically would fill the need.

Matters tied directly to psychiatric care are also potential areas for additional clinic involvement. In the late 1990s, ARCH, a specialty clinic for persons with disabilities, brought a claim against a psychiatric facility after the death of a person who had been detained in a manner allegedly non-compliant with the law and restrained by facility staff.¹⁷ He died while in restraints. The case, started in Small Claims Court but finally dealt with at the Court of Appeal, involved issues of illegal detention, battery, and vicarious liability. The claim, a non-traditional matter for legal clinics, would not likely have been taken on by the private bar because of funding issues and other difficulties. The clinic's initiative ensured that significant issues were dealt with by the courts, and a family obtained access to the justice system to raise their concern in a public forum.

Similar rights violations may arise both in and out of hospital and may touch on illegal detention, breaches of confidentiality, and illegal treatment. Sadly, while persons involved in psychiatric services have a number of stated rights in legislation, very little

16. Community Legal Services of York Region worked together with the Krasman Centre and other community organizations on the Bill of Rights, on by-law regulation and other issues affecting housing for this client group.

17. *Re: The Estate of Thomas Frederick Illingworth v. Humber Memorial Hospital* (1999) Docket C32011.

is done to enforce those rights. Clinics could play a tremendous role in fundamental human rights issues.

CONCLUSION

Many clinics and individual caseworkers are already providing excellent services to persons with SMI, and their work has greatly increased their clients' ability to access justice and to more effectively participate in the legal aspects of their lives. Unfortunately, there are too few persons in the clinic system doing this type of work, and clients are faced with inconsistent service, depending on their catchment area. Ideally, Legal Aid Ontario will lead in determining the needs of these clients and meeting those needs, particularly on the intersection of services between the private bar and clinics. Both local and provincial needs assessments are necessary to identify the types of services required and the appropriate role for legal clinics. Leadership must also be demonstrated within the clinic system to address education and skill needs of clinic staff, while working groups can be formed to develop draft standard policies and procedures.

Beyond that, individual clinics must look at the extent to which they are presently providing services to persons with SMI and consider how they can serve this group more effectively. With effective education and preparation, the clinic legal aid system can provide effective, consistent legal services across the province for persons with mental illness, providing access to the justice system that is often still denied.

On a personal note, working with persons with SMI has been among the most rewarding experiences of my professional life. It has been a privilege to be trusted with the challenges, dreams, goals, and personal stories of my clients. I encourage clinics and individual caseworkers to challenge themselves to become better advocates for persons with mental illness and to act in all possible ways to increase their access to justice.