CANADIAN MENTAL HEALTH ASSOCIATION
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WINNIPEG REGION

PUBLIC INTEREST LAW CENTRE
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EQUALITY, DIGNITY AND INCLUSION: LEGISLATION THAT ENHANCES HUMAN RIGHTS FOR PEOPLE LIVING WITH MENTAL ILLNESS

FINAL REPORT

Submitted to:
Evaluation Project Committee,
Mental Health and the Law Advisory Committee,
Mental Health Commission of Canada

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The Project Research Team would like to acknowledge the Mental Health Commission of Canada for funding this Project and the Mental Health & the Law Advisory Committee for having the vision and foresight to develop this Project. The ongoing direction provided by the Project Evaluation Committee was valuable in ensuring that the Project remained true to its objectives. The outcomes of this Project would not have been as comprehensive as they are without the participation and input from the members of the Project's Consultation Group, the individuals that participated in focus group sessions and interviews, and the individuals who led and participated in the piloting of the Evaluation Instrument. The contribution of the members of the Consultation Group in particular was valuable in making the crucial link between relatively abstract concepts such as legislation, policy, standards and human rights and the everyday, lived experience with mental illness. The poignant stories shared have put a face to mental illness and human rights and are what have made this Project meaningful.

Preamble from the Mental Health Commission of Canada:

Changing Directions, Changing Lives: The Mental Health Strategy for Canada released by the Mental Health Commission of Canada (MHCC) in 2012 states Canada's ratification of the United Nations Convention of the Rights of Persons with Disabilities (CRPD) provides a new touchstone for legislation, policies and regulations. The *Strategy* includes a strong focus on upholding the rights of people living with mental health problems and illnesses. It makes several recommendations for action including removing barriers to full participation in workplaces, schools, and other settings (Recommendation 2.3.1), reviewing and, where necessary, updating legislation and revising policies across jurisdictions and sectors to achieve alignment with the CRPD (2.3.3), reducing and eventually making seclusion and restraint virtually unnecessary (2.3.4), and supporting advocacy by people living with mental health problems and illnesses and their families (2.3.5). In addition, the *Strategy* makes recommendations that are relevant for upholding the social rights of people living with mental health problems and illnesses, such as access to treatment, housing and employment.

While this Project Report cannot be taken as representing the position of the MHCC, a key part of the MHCC's role is to encourage debate and discussion amongst a broad range of stakeholders on important mental health policy issues. The MHCC welcomes other organizations with an interest in upholding the rights of people living with mental health problems and illnesses to build on the contribution of the research team, project team, and consultation group.

While the MHCC shares a commitment to upholding the rights of people living with mental health problems and illnesses, the views expressed herein are solely those of the authors and cannot be taken as representing the positions of the MHCC.

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EXECUTIVE SUMMARY

The UN Convention on the Rights of Persons with Disabilities (CRPD) is an international treaty and the first of its kind to focus specifically on persons with disabilities, including persons living with a mental illness. The purpose of the CRPD is to "promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity." (CRPD, Article 1) The CRPD was developed on the basis that persons living with a disability continue to be denied their human rights and are kept on the margins of society across the world despite the numerous human rights treaties already in existence.

The CRPD does not create new rights for persons with disabilities, but rather consolidates and amplifies existing human rights and sets out the legal obligations for countries to protect and advance the rights of persons living with a disability. The 50 Articles within the CRPD include key human rights such as Article 6 – Equality and Non-discrimination, Article 10 - Right to Life and Article 14 – Liberty and Security of the Person as well as social rights such as Article 19 – Living Independently in the Community, Article 24 – Education, and Article 27 – Work and Employment.

The CRPD has effectively raised the bar on the issue of disability rights by clearly articulating the relationship between existing human rights and persons living with disabilities and has led to discussions and actions world wide on a subject matter that was rarely discussed and acted upon previously. The CRPD has also aroused debate internationally and in Canada around issues of legal capacity to make decisions and involuntary committal and treatment. The implementation of psychosocial rehabilitation and recovery approaches as well as improved psychiatric medication in the treatment of mental illness provides better options for persons living with a mental illness. Yet, despite these advancements, the debate remains polarized between protecting society from the perceived danger attributed to people living with a mental illness and protecting individual rights and freedoms and promoting inclusion in society. The former leads to a paternalistic approach whereby the will of others is imposed and disguised as the 'best interests' of persons living with a mental illness. Unfortunately, as this debate continues, the rights of persons living with a mental illness in Canada and elsewhere continue to be violated, and the potential to address their human rights has not been explored.

On March 11, 2010, Canada ratified the CRPD, and as set out on Article 33(2) has an obligation to implement the guiding principles and human rights of persons living with a disability and monitor and report its progress. Furthermore, Canada along with other signatory countries is obligated to "establish within the State Party, a framework, including one or more independent mechanisms, as appropriate, to promote, protect and monitor implementation of the present Convention." Canada was one of the most engaged delegations in the development and negotiation of the CRPD, and in many ways the world is looking to Canada to take the lead in implementing and monitoring the principles and rights in the CRPD. However, during the course of the Project, the Project Research Team was advised that to date Canada has not yet

developed a national plan on how the principles and rights contained in the CRPD will be implemented nor has it designated an independent mechanism responsible for monitoring and reporting on the implementation of the CRPD.

A preliminary assessment of Canada's existing mental health legislation, policies and standards shows little evidence of alignment with human rights. Instead, existing provincial/territorial mental health legislation is focused in large part on restricting individual rights, for example setting out the criteria for when a person can be involuntarily admitted to a mental health facility or when a substitute decision-maker can be appointed. Absent from mental health legislation is a focus on 'positive rights' and obligations on the part of government to protect and promote the rights of persons living with a mental illness, for example, the right to health care and the right to education. Furthermore, provincial/territorial mental health policies and standards appear to be more reactionary than purposeful attempts to uphold and advance an individual's human rights.

The CRPD provides a basis from which existing mental health laws, policies, and standards may be examined and evaluated to see if they reflect its principles and uphold fundamental human rights. Members of the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada (MHCC) as well as individuals external to the Committee formed a sub-committee ('Evaluation Project Committee') and took active steps to develop a research project ('the Project') to create a mechanism to evaluate existing mental health legislation, policies and standards for the purpose of learning the extent to which they measure up against the principles and rights of the CRPD. The Canadian Mental Health Association – Winnipeg Region office in partnership with the Public Interest Law Centre of Legal Aid Manitoba and an independent researcher were the successful proponents to lead the Project. The Project commenced on April 1, 2010 and concluded in October 2011.

The premise of the Project is that mental health legislation, policies and standards form the framework for how persons living with a mental illness are perceived and included in society and impact quite directly on most aspects of their lives. This framework is the basis for mental health practice and if the human rights of persons living with a mental illness are to be protected, then legislation, policies and standards should be grounded in human rights.

The primary goal of the Project is to develop and pilot an instrument to measure and evaluate the degree to which human rights are incorporated into existing provincial and territorial mental health legislation, polices and standards. The instrument would be used by government and non-government entities to assess the current status within their respective province or territory. The results of the evaluation would form the basis for provincial/territorial legislative reform, and policy and standard development. The results would also be used in Canada's monitoring and reporting process required by the CRPD.

In order to achieve this goal, the objectives of the Project were as follows:

1. To develop an instrument to evaluate the extent to which human rights are addressed in existing legislation, policies and standards as they relate to persons living with a mental illness;
2. To conduct a preliminary assessment of the existing legislation, policies and standards as it relates to persons living with a mental illness;
3. To draft a set of recommendations pertaining to the Evaluation Instrument; legislative reform; and policy and standards development; and,
4. To develop a strategic plan that guides the dissemination of the Evaluation Instrument to federal and provincial/territorial governments and promotion of its use as part of the monitoring function of the CRPD in Canada.

The Project methodology was centered on the collaboration with and participation of persons with lived experience, family members, service providers, non-government mental health organizations and provincial governments. The three mechanisms established for collaboration and participation consisted of pilot jurisdictions, stakeholder focus group sessions, and a Consultation Group consisting of persons with lived experience.

As each province and territory has a different approach to address the treatment, protection and inclusion of persons living with a mental illness, three provinces were chosen as pilot sites and sources of information regarding existing legislation, policies and standards; namely, Nova Scotia, Manitoba, and British Columbia. Stakeholder focus group sessions were held in the three pilot jurisdictions to gather the contextual information regarding the current status and practice related to mental health legislation, policies and standards. In addition, a Consultation Group consisting of persons with lived experience and representing the pilot jurisdictions as well as Quebec and a northern territory was formed for the purpose of guiding the Project Research Team and ensuring that the experiences of persons living with a mental illness were honoured and incorporated into each step and deliverable of the Project.

It is important to note that although one of the Consultation Group members was able to bring some of the concerns of northern Aboriginal people to the discussions, the Project Research Team recognized at the outset the unique needs of Aboriginal people living with a mental illness and acknowledged the essential need for Aboriginal people, including First Nations, Métis and Inuit, to be involved in the process of evaluating mental health legislation, policies and standards.

The insight provided by the Consultation Group members was particularly valuable to the Project as it ensured that the lived experience remained central to the formation of the Evaluation Instrument. The views and experiences of the Consultation Group members are poignantly illustrated through a Photovoice presentation that consists of pictures taken by the Group's members and accompanied by their voices in describing their views of human rights and mental illness. This powerful visual presentation can be found and viewed at www.cmhawpg.mb.ca/MHCCproject.htm.

The Mental Health and Human Rights Evaluation Instrument (Evaluation Instrument) was developed based on a review of existing evaluation instruments, domestic legislation, policies and standards; the information obtained through the stakeholder focus group sessions; and, the input received from the Consultation Group. The Evaluation Instrument was piloted in Nova Scotia, Manitoba and British Columbia with the intention that it be applied in all provinces and territories following the completion of the pilot process. The responses to the Evaluation Instrument provided by the Pilot Evaluation Teams in each jurisdiction, along with the findings from the information gathering process, contributed to a preliminary human rights assessment of each pilot province's existing legislation, polices and standards. Feedback received from the pilot jurisdictions and the Project Evaluation Committee regarding the Evaluation Instrument has been incorporated into a revised version, which is appended to this report as a separate document.

The implications of all research findings form the basis for recommendations pertaining to the Evaluation Instrument; legislative reform; policy development; standards development; and monitoring human rights in the mental health sector as it relates to the CRPD. The recommendations are summarized below.

RECOMMENDATIONS:

The recommendations outlined below are to be interpreted with the understanding that all activities associated with the evaluation of mental health legislation, policies and standards, as well as the CRPD monitoring and reporting functions are conducted with the involvement and participation of persons living with a mental illness including women and Aboriginal people.

A. Mental Health and Human Rights Evaluation Instrument

Training

- Training on the Evaluation Instrument should be provided to all participants in the evaluation process including the facilitator(s).
- Training on the Evaluation Instrument should be provided at a minimum for one full day to allow for sufficient practice in its use.
- Training should include an orientation to the evaluation process; instruction on the legislation, policies and standards to be evaluated; and the key rights as they pertain to persons living with a mental illness.
- Training should include instruction on completing responses in the Evaluation Instrument such as including references to specific sections of legislation, policies and standards; the analytical process to determine the response to an evaluation question; and how to fully complete a response to an evaluation question.
- Training should include practice examples taken from actual legislation, policy and standards so that participants can become better versed in the Evaluation Instrument.

Process to Evaluate Legislation, Policies and Standards

- All participants should receive or have access to all material related to the evaluation including the legislation, policies and standards being evaluated at a minimum one week before the evaluation process begins to allow ample time for participants to read and become familiar with the documents being evaluated.
- The time to complete the Evaluation Instrument should be increased from three months to a minimum of six months to allow for a thorough and complete evaluation of legislation, policy or standard, and the timeframe should be flexible to accommodate the participants' schedules.
- The Evaluation Instrument should be completed using a facilitated small group discussion format in which there are separate individuals fulfilling the facilitation and recording functions.
- The participants in the evaluation exercise should include a range of individuals that can provide information about similarities and differences between a law, policy, or standard and the experiences in practice. The participants should include at a minimum sector representatives from law (lawyers, judges), government (policy-makers), non-government (advocates), health facilities/organizations (service providers including psychiatrists and community mental health workers), as well as persons living with a mental illness, and family members. In addition, individuals with an ability to analyze legislation, policies and standards should be included in the group of evaluation participants.

Changes to the Evaluation Instrument

- The Evaluation Instrument should include references to terms defined in the glossary throughout the document.
- The instructions on how to complete the Evaluation Instrument should be revised to be more comprehensive and clear.
- The length of the Evaluation Instrument should be shortened by eliminating duplication in the evaluation questions; however, it is also necessary that evaluation questions be added based on specific feedback from the evaluation participants.
- The scoring scale for the evaluation questions, namely 'Addressed in Full', 'Partially Addressed', and 'Not at all Addressed', should be more clearly defined in the instructions for the Evaluation Instrument.
- The response sections of the Evaluation Instrument should be adjusted to capture information related to the realization of the legislation, policy or standard in practice.
- The response sections of the Evaluation Instrument should be revised to include an area where evaluators can provide their recommendations following the identification of what in the legislation/policy/standard has been addressed and what is missing in relation to a particular right.

- The formatting of the Evaluation Instrument should be changed so that the sections on legislation, policy and standards are sufficiently clear to the evaluator.
- The Evaluation Instrument should be tailored to the provincial/territorial context. For example, if there are no provincial/territorial policies, then these sections should be deleted from the Evaluation Instrument and a notation inserted that a deletion was made and the reason for the deletion. Also, the names of the specific legislation, policy or standard being evaluated should be inserted into the Instrument.

Completing and Submitting Responses

- An electronic version of the Evaluation Instrument should be developed that provides ample space for responses.

B. Provincial/Territorial Evaluation of Mental Health and Human Rights

- As Canada is a Federation and many of the rights contained in the CRPD either fall under the responsibility of the provincial/territorial governments or there is overlapping responsibility between the federal and provincial/territorial governments, it is recommended that each province and territory undertake an evaluation of their mental health legislation, policies and standards.
- Mental health legislation, policy and standards should be evaluated against the CRPD using the Evaluation Instrument so the human rights of persons living with a mental illness are respected and are not over-looked.
- A plan should be developed by each province/territory based on the evaluation results to reform legislation, and develop policies and standards.

C. Legislative Reform

- Within each province/territory, there are several laws in addition to mental health legislation that impact persons with living with a mental illness. It is recognized that it may not be feasible for all of the principles and rights contained in the CRPD to be addressed in a single Mental Health Act, and as such, other legislation will need to be assessed to ensure they are all addressed.
- Provincial/territorial mental health legislation could be amended to include the obligations of government to protect and advance the rights of persons living with a mental illness as outlined in the CRPD, in particular:
    - Limiting the use of substitute decision-making by indicating it is a method of last resort and promoting supported decision-making as the preferred method of decision-making (Article 12).
    - Providing a definition of torture and cruel and degrading treatment that includes a reference to the misuse of seclusion and restraint practices, and stipulating that measures should be taken to reduce such practices (Article 15).

- Providing a definition of accessibility as it pertains to persons living with a mental illness that includes attitudinal barriers to access such as stigma and prejudice, and the government's obligation to address access issues (Article 3).
- Maintaining a balance between an individual's human rights and the protection of society by emphasizing that involuntary committal and treatment are a last resort when all other options have been attempted (Article 14).
- Requiring that an individual not only has the right to counsel or an agent when appearing before the Mental Health Review Board, but also additional measures be taken to realize this right in a meaningful way. For example, the legislation could require the Review Board appoint a representative to appear at the hearing and act on the person's behalf if the person is unable to attend the hearing and has not appointed someone else to act on his/her behalf (Article 13).

- Provincial/territorial mental health legislation could be amended to incorporate the promotion of positive rights, as outlined in the CRPD, namely: the right to live independently and be included in the community, including the right choose housing and the right to a range of in-home and community supports (Article 19); the right to employment and employment supports (Article 27); the right to education and education supports (Article 24); and, the right to an adequate standard of living and social protection (Article 28).
- The *Criminal Code* and the interface with provincial/territorial mental health legislation raises specific issues related to human rights violations that require specific attention, research, and recommendations.

D. Policy Development

- Provincial/territorial policies should be developed to address the human rights of persons living with a mental illness and they should be applicable to all mental health facilities, and organizations, as well as regional and district health authorities. The policies developed should derive their authority from mental health legislation and also contain enough detail to set the direction of how mental health services are delivered with the protection of human rights in mind. For example, there could be a provincial/territorial policy that directs minimizing the use of restraint and seclusion practices with a goal of eliminating these practices.
- Mental health policies developed at the facility/organization and region/district levels should mirror or be an extension of, and not conflict with provincial/territorial mental health policies. Mental health policies developed at all levels should be coordinated to avoid a patchwork of conflicting policies across a province/territory.

- Provincial/territorial mental health policies should include a description of the mechanism to monitor the implementation of the policy to determine if it is being effectively implemented within the facility, organization, region or district.

E. Standards Development

- Provincial/territorial standards for mental health services should be developed that echo the principles and rights found in the CRPD and should derive their authority from legislation and policies.
- If a province/territory develops mental health service standards, then it is crucial that an external, independent body be mandated with the responsibility to monitor a facility's or an organization's ability to meet those standards. Voluntary self-assessment is not sufficient.
- If a province/territory chooses to rely on the Accreditation Canada process to evaluate mental health services according to a set of standards, then the standards should be adjusted to reflect the principles and rights in the CRPD and the organization being evaluated should be required to report its evaluation results to funders, e.g. government, and a monitoring body.

F. National Human Rights Monitoring in the Mental Health Sector

- A nation-wide dialogue on mental health and human rights should be initiated and facilitated and include the links between the key principles and rights in the CRPD and the current status and potential impact on persons living with mental illness.
- In the absence of a national plan to implement and monitor the principles and rights contained in the CRPD, it is recommended that such a plan be developed, and ideally, be developed by a coalition of national non-government disability organizations and human rights organizations, including a national mental health organization whose principles and values mirror those in the CRPD.
- If a national independent mechanism is established to monitor the implementation of the CRPD, then the mental health community including non-government mental health organizations such as the MHCC should work collaboratively with this entity as well as the broader disability community to ensure that issues specifically relevant to persons living with a mental illness are known and incorporated into the monitoring plan.

STRATEGIC PLAN:

Despite Canada's significant presence and involvement in the development of the CRPD, its content and implications for persons living with a mental illness are not well known nor widely discussed. The MHCC is a national, non-government mental health organization, and as such is in a position to assist in facilitating a nation-wide dialogue on mental health and human rights. Furthermore, Canada is required to submit its first report to the UN Committee on the CRPD on

its progress in implementing its obligations under the CRPD by March 2012 and every four years thereafter. The Evaluation Instrument developed to assess provincial/territorial mental health legislation, policies and standards and the subsequent results could provide a meaningful and comprehensive analysis of the current status of mental health and human rights. The evaluation results could provide the rationale and basis for provincial/territorial legislative reform, policy and standard development as well as lay the foundation for a national report to the UN. On this basis, the following Strategic Plan centers on the evaluation of mental health and human rights and a national process to monitor the implementation of Canada's obligations under the CRPD as they relate to persons living with a mental illness. These two processes are interdependent, and in order to be effective and do justice to the CRPD they should occur simultaneously.

Evaluation and Implementation of Mental Health and Human Rights

A. MENTAL HEALTH AND HUMAN RIGHTS EVALUATION INSTRUMENT			
RECOMMENDATION	**ACTIONS**	**RESPONSIBLE**	**TIME FRAME**
Revise Evaluation Instrument based on recommended changes	1. Incorporate the recommended changes into a revised version of the Evaluation Instrument.	Project Research Team	Completed
	2. Incorporate the recommended process to complete the evaluation into a revised version of the Evaluation Instrument.	Project Research Team	Completed
Provide training on the Evaluation Instrument	1. Release to the public the Project's Final Report, Evaluation Instrument and Photovoice presentation.	MHCC	December 2011
	2. Provide training in the use of the Evaluation Instrument.	MHCC or other non-government mental health organization.	January – March 2012

B. PROVINCIAL/TERRITORIAL EVALUATION OF MENTAL HEALTH AND HUMAN RIGHTS			
RECOMMENDATION	**ACTIONS**	**RESPONSIBLE**	**TIME FRAME**
Each province and territory undertakes an evaluation of their mental health legislation, policies and standards.	1. Each province and territory evaluates their laws, policies and standards against the principles and rights contained in the CRPD.	Provinces and territories	March – December 2012
Provincial/territorial laws, policies and standards are evaluated against the	1. Each province and territory uses the Evaluation Instrument	Provinces and territories	March – December 2012

B. PROVINCIAL/TERRITORIAL EVALUATION OF MENTAL HEALTH AND HUMAN RIGHTS			
RECOMMENDATION	**ACTIONS**	**RESPONSIBLE**	**TIME FRAME**
CRPD using the Evaluation Instrument.	to assess current laws, policies and standards.		
Each province and territory develops an action plan based on the evaluation results.	1. Each province and territory develops an action plan to reform legislation, and develop policies and standards based on the evaluation results.	Provinces and territories	January – June 2013

C. LEGISLATIVE REFORM			
RECOMMENDATION	**ACTIONS**	**RESPONSIBLE**	**TIME FRAME**
Legislation in addition to mental health legislation should be assessed for inclusion of human rights.	1. Provinces and territories should assess all laws that may impact persons living with a mental illness for inclusion of human rights	Provinces and territories	March – December 2012
Provincial/territorial mental health legislation could be amended to include obligations of government to protect and advance the rights of persons living with a mental illness.	1. Provincial/territorial laws are amended based upon the evaluation results and noting in particular the recommended changes outlined in Section C of the Recommendations.	Provinces and territories	July 2013 onward
Provincial/territorial mental health legislation could be amended to incorporate positive rights as outlined in the CRPD.	1. Provincial/territorial laws are amended to include the positive rights contained in the CRPD.	Provinces and territories	July 2013 onward
The *Criminal Code* and the interface with provincial/territorial mental health legislation raises specific issues related to human rights violations that require specific attention, research, and recommendations.	1. A research project is initiated that focuses on the interface between provincial/ territorial mental health legislation and the *Criminal Code* as it relates to human rights.	To be determined	

D. POLICY DEVELOPMENT			
RECOMMENDATION	**ACTIONS**	**RESPONSIBLE**	**TIME FRAME**
Provincial/territorial mental health policies should be developed to	1. Provinces/territories develop mental health policies based on the	Provinces and territories	July 2013 onward

D. POLICY DEVELOPMENT			
RECOMMENDATION	**ACTIONS**	**RESPONSIBLE**	**TIME FRAME**
address the human rights of persons living with a mental illness and should derive their authority from mental health legislation.	evaluation results and stem from legislation with sufficient detail provided to direct mental health service delivery.		
Mental health policies at facility, regional, and provincial levels should be coordinated for consistency.	1. Provinces/territories establish a coordination mechanism so that the mental health policies developed at all levels are consistent.	Provinces and territories	July 2013 onward
Provincial/territorial policies should include a description of the mechanism to monitor the implementation of the policy at facility, organization, region and district levels.	1. Provinces/territories establish a mechanism to monitor the implementation of mental health policies.	Provinces and territories	July 2013 onward

E. STANDARDS DEVELOPMENT			
RECOMMENDATION	**ACTIONS**	**RESPONSIBLE**	**TIME FRAME**
Provincial/territorial mental health standards should be developed that reflect human rights principles and are consistent with mental health legislation and provincial/territorial policies.	1. Provinces and territories develop mental health standards that are based on the evaluation results and are consistent with mental health legislation and policies.	Provinces and territories	July 2013 onward
An external, independent body should be mandated with the responsibility of monitoring a facility's or organization's ability to meet mental health standards.	1. Provinces and territories mandate an external, independent body to monitor mental health standards.	Provinces and territories	July 2013 onward
If a province/territory chooses to rely on Accreditation Canada to set standards, then the standards should be adjusted to reflect human rights and the results reported to government	1. Provinces and territories choosing to rely on Accreditation Canada standards should ensure that the standards reflect human rights principles and the	Provinces and territories	July 2013 onward

and a monitoring body.	results are reported to government and an external monitoring body.		

National Human Rights Monitoring in the Mental Health Sector

F. NATIONAL HUMAN RIGHTS MONITORING IN THE MENTAL HEALTH SECTOR			
RECOMMENDATION	**ACTIONS**	**RESPONSIBLE**	**TIME FRAME**
A nation-wide dialogue on mental health and human rights should be initiated and facilitated and include the links between the key principles and rights in the CRPD and the current status and potential impact on persons living with mental illness.	1. The MHCC acts as a catalyst in raising awareness and facilitating a dialogue among governments, non-government organizations, and the public on mental health and human rights as they relate to the CRPD.	MHCC	December 2011 onwards
A national plan to monitor the CRPD be established by a coalition of national non-government disability organizations including mental health organizations whose principles mirror those in the CRPD and human rights organizations.	1. The MHCC along with other national mental health organizations promotes and supports the development of a coalition of disability organizations including mental health organizations and human rights organizations to form a coalition for the purpose of monitoring of the CRPD.	MHCC and other national mental health organizations	December 2011 onwards
	2. The coalition creates a shadow report for submission to the UN on the progress of implementing the CRPD and uses the results of the provincial/territorial mental health and human rights evaluation to form part of its basis.	Coalition of Disability Organizations	December 2011 – December 2012
If a national independent	1. The MHCC encourages	MHCC	November 2011 – ongoing

F. NATIONAL HUMAN RIGHTS MONITORING IN THE MENTAL HEALTH SECTOR			
RECOMMENDATION	**ACTIONS**	**RESPONSIBLE**	**TIME FRAME**
mechanism is established to monitor the implementation of the CRPD, then the mental health community including non-government mental health organizations such as MHCC should work collaboratively with this entity to ensure that issues specifically relevant to persons living with a mental illness are known.	mental health organizations to take an active role in representing the interests of persons living with a mental illness in the national monitoring process.		
	2. The independent monitoring mechanism involves persons living with a mental illness in its processes, similar to the Consultation Group model used in this Project.	Independent Monitoring Mechanism (to be established)	Once an independent monitoring mechanism is established.

I. INTRODUCTION

This report summarizes the work, findings, and recommendations of a research project funded by the Mental Health Commission of Canada (MHCC) and developed by members of the Mental Health & and Law Advisory Committee affiliated with MHCC. The Project entitled *Equality, Dignity, and Inclusion: Legislation that enhances human rights for people living with mental illness* was conducted by the Canadian Mental Health Association – Winnipeg Region office in partnership with the Public Interest Law Centre of Legal Aid Manitoba and an independent researcher.

The Project's focus is to create a method to evaluate existing mental health legislation, policies and standards to learn the extent to which they incorporate the principles and rights contained in the UN Convention on the Rights of Persons with Disabilities (CRPD). The CRPD is a foundational international treaty that lays out the obligations of signatory countries to protect and advance the rights of all persons with disabilities, including persons living with a mental illness. Canada ratified the CRPD in March 2010 and is required to submit a report to the United Nations by March 2012 on its progress in implementing its obligations under the CRPD. The Mental Health and Human Rights Evaluation Instrument (Evaluation Instrument) developed by the Project Research Team and appended as a separate document is intended for use by government and non-government entities to assess the current status of their respective provincial/territorial legislation, policies and standards. The expectation is that the results from the evaluation would form the basis for provincial/territorial legislative reform, and policy and standard development. Furthermore, the results would be used as part of Canada's monitoring and reporting process required by the CRPD.

This report outlines the background on the Project's inception and the Project Research Team; the Project's framework including the current context of mental health and human rights in Canada; the Project's goal, objectives and methodology; a summary of the research findings and implications of the findings; and concludes with recommendations stemming from the findings and a strategic plan that identifies the actions and timelines associated with each recommendation.

II. BACKGROUND

A. Project Inception

The Mental Health & the Law Advisory Committee (Committee), one of eight Advisory Committees guiding the work of the Mental Health Commission of Canada (MHCC), is responsible for examining how society considers the rights of people living with a mental illness, and in particular the way in which the legal system impacts these rights. The Committee recognizes that persons living with a mental illness have been historically marginalized, and that

Canada's legislative framework has the potential to infringe upon an individual's rights rather than promote the government's positive obligations to protect and promote human rights.
On this basis, members of the Committee and individuals external to the Committee formed a sub-committee known as the Evaluation Project Committee. The Evaluation Project Committee identified the need for an evaluative instrument to analyze the extent to which existing Canadian law acknowledges and protects the human rights of people experiencing mental health issues. The instrument developed would build upon the work of a similar nature conducted in international jurisdictions including Scotland (Scottish Recovery Index, http://www.scottishrecoveryindicator.net/; Australia (Rights Analysis Instrument, http://www.healthyactive.gov.au/internet/main/publishing.nsf/Content/mental-pubs-r-rights); the Council of Europe (http://www.coe.int/t/dg3/health/mental_en.asp); and the World Health Organization (http://www.who.int/mental_health/policy/WHOLegislationChecklist.pdf).

Furthermore, the instrument would assess not only law, but also policies and standards and the degree to which they do or do not address key human rights. Subsequently, in late 2009, the MHCC issued a Request for Proposals (RFP) for the Mental Health & the Law Advisory Committee: Evaluation Project. The Evaluation Project Committee was then responsible for receiving the proposals, choosing the successful project proponent, and over-seeing the Project. Members of the Evaluation Project Committee include:

H. Archibald Kaiser -	Schulich School of Law, Dalhousie University, Nova Scotia
Cindy Player -	Equity and Human Rights Office, University of Victoria, British Columbia
Judith Mosoff -	Faculty of Law, University of British Columbia
Peter Carver -	Faculty of Law, University of Alberta
Mary Marshall -	Lawyer, Edmonton, Alberta
Sophie Sapergia -	Mental Health Commission of Canada, Calgary, Alberta

B. Project Research Team

The Canadian Mental Health Association - Winnipeg Region in partnership with the Public Interest Law Centre (PILC) of Legal Aid Manitoba and an independent researcher was the successful Project proponent. The Project officially commenced on April 1, 2010. The members of the Project Research Team were:

Project Manager -	Nicole Chammartin, Executive Director, CMHA – Winnipeg
Principal Researcher -	Christine Ogaranko, Independent Consultant
Legal Researcher -	Beverly Froese, Attorney, Public Interest Law Centre, Legal Aid Manitoba
Legal Advisor -	Byron Williams, Director, Public Interest Law Centre, Legal Aid Manitoba
Researcher (Photovoice) -	Dr. Gayle Restall, Associate Professor, University of Manitoba

The Project's objective and activities were consistently guided by the input received from the Project's Consultation Group; a group of persons with lived experience. More detailed information regarding the membership and role of the Consultation Group is provided in Section V.

III. PROJECT FRAMEWORK

A. Mental Health Legislation, Policy and Service Standards – the Canadian Context

Mental health legislation, policies and service standards provide the framework for mental health practice and 'set the tone' for how persons living with a mental illness are perceived by society; how they are 'treated' medically; and, the extent to which they are supported in the community.

Laws (as defined by the Project Research Team) are enacted through a democratic legislative process and in general establish the overall framework to achieve a specific government objective or to address a specific social issue. Law also emerges from the judiciary as judges interpret legislation or consider the *Charter of Rights and Freedoms* and other aspects of constitutional law. Legislation often creates or confirms legal rights and obligations and frequently grants authority to the government to make regulations detailing how the law will be administered.

Policies (as defined by the Project Research Team) are an interpretation of the legislation. They are generally not legally binding, but instead are intended to provide guidance and direction as to how the legislation is to be implemented and/or how services are to be provided on a day to day basis. The term 'policy' is often used interchangeably within government with terms such as 'strategy' or 'action plan'.

Standards (as defined by the Project Research Team) are measurable minimum levels of what is considered to be accepted practice in a particular service and may be voluntary or mandatory. Standards are intended to promote consistency, safety and quality and in the health service field, they can apply to both facility-based and community-based services.

In the mental health field, implementation of legislation, policies and service standards can be complex. Often there are multiple architects and competing or conflicting values and principles at play. For example, mental health legislation as it stands permits involuntary admission to hospital, while mental health policies may promote individual choice for treatment. In many Canadian jurisdictions, there are multiple laws that have an impact on the treatment and support for persons living with a mental illness. For example, one law addresses how and under what circumstances a person may be admitted to a mental health facility, while another deals with if and how a person can access their personal health information.

It is also a commonly shared characteristic across the country that mental health legislation does not go much beyond establishing criteria for involuntary committal and/or treatment (either in mental health facilities or in the community) and substitute decision-making. In other words, the focus of mental health laws is primarily on restricting individual rights and freedoms rather than on imposing positive obligations on government to respect and support a person's choices and living the life of their choosing.

Much like legislation, mental health policies are often developed by different stakeholders for different purposes, and reflect competing values and principles. They are developed at the provincial or territorial level, and also at the regional and facility levels. Mental health policies cover a wide variety of issues relating to service delivery, for example eligibility for a particular program and the conduct of staff.

There is great potential for provincial and territorial governments to establish mental health policies in their jurisdictions to ensure the rights of persons living with a mental illness are respected. For the most part, however, provincial and territorial governments have created very few, with the result being a patchwork of policies developed at a regional or facility level that are not necessarily focused on promoting and protecting the rights of persons living with a mental illness.

Canadian mental health service standards are a mixed variety with multiple sources. There are system-level standards such as 'wait times' to access mental health services that are developed by provincial/territorial governments as part of their overall health strategy; mental health facility-based standards relating to interventions such as the use of restraint and seclusion; and program-specific standards such as British Columbia's Program Standards for Assertive Community Treatment Teams.

Accreditation Canada has developed three sets of standards related to mental health service systems and service delivery, namely: 1) mental health service delivery primarily within in-patient settings; 2) mental health population standards focusing on regional or systems perspectives on the flow of service users and the transfer of information; and 3) the recently launched community-based service standards. Many regional health authorities and mental health facilities participate in Accreditation Canada's voluntary accreditation process. The community-based service standards in particular address some individual rights such as informing persons living with a mental illness of their rights, the right to privacy, the right to refuse services, and the right to informed consent. However, there is no mechanism for facilities or services to report the results i.e. the extent to which they meet certain standards, of their accreditation evaluation outside of the facility/organization or Accreditation Canada.

B. Canada's *Charter of Rights and Freedoms*

Canada's Constitution, and more specifically the *Canadian Charter of Rights and Freedoms* ("the *Charter*"), lays the foundation for the protection of fundamental human rights and freedoms.

The *Charter* is the "supreme law" of Canada from which other laws are measured. The *Charter* applies to governments, i.e. federal, provincial/territorial, municipal governments and agents for the government, such as local police services and the R.C.M.P. Any law, either federal or provincial/territorial, that conflicts with the *Charter* is considered to be unconstitutional and not legally valid. Similarly, a government policy or action that violates the *Charter* is also considered to be unconstitutional.

The rights and freedoms guaranteed under the *Charter* are not absolute. Section 1 expressly recognizes that in a free and democratic society, there may be circumstances when the government is justified in violating individual rights, for example in order to achieve a sufficiently important objective. For that reason, a challenge to a law or government action under the *Charter* proceeds in two stages: (1) the claimant must first prove that his/her right has been violated; and (2) if the claimant is successful, then the burden of proof shifts to the government to prove the violation is justified.

Several provisions of the *Charter* are particularly relevant to the application and interpretation of mental health legislation, regulations and policies, for instance:

1. Section 7 guarantees "the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice". The Supreme Court of Canada has interpreted "liberty" to mean freedom from physical restraint, for example confinement in a prison or mental health facility. It has interpreted "security of the person" to include the right to control one's own body, for example by refusing medical treatment, and the right to make decisions that are fundamental to personal identity. Section 7 also includes protection against laws or government action that arbitrarily prevents access to necessary medical care.

2. Section 9 guarantees "the right not to be arbitrarily detained or imprisoned". This section has arisen in the context of involuntary admission criteria set out in mental health legislation.

3. Section 10 guarantees certain rights upon detention, for example in a mental health facility, namely: "(a) to be informed promptly of the reasons therefore; (b) to retain and instruct counsel without delay and to be informed of that right; and (c) to have the validity of the detention determined by way of *habeas corpus* and to be released if the detention is not lawful".

4. Section 12 guarantees "the right not to be subjected to any cruel and unusual treatment or punishment". In the context of mental health legislation and policies, this section is relevant to conditions in a mental health facility or the conduct of staff.

5. Section 15(1) guarantees every individual the right to equal recognition under the law, and equal protection and benefit of the law. These equality rights prohibit discrimination on the basis of a number of enumerated and analogous grounds, including mental or physical disability.

Although the *Charter* is the supreme law in Canada, violations of the human rights of persons living with a mental illness continue to occur. There have been a number of *Charter* cases that have been successful, however enforcing individual rights and ensuring that laws and government action comply with the *Charter* may pose significant challenges. For instance, many vulnerable individuals, particularly persons living with a mental illness, are either not aware of their *Charter* rights or do not know how to go about enforcing them. Further, because the onus is on individual claimants to challenge a law or government action, there are serious access to justice concerns. *Charter* claims may be expensive to litigate and it is often very difficult for persons living with low income to be able to find legal representation.

C. UN Convention on the Rights of Persons with Disabilities

The UN Convention on the Rights of Persons with Disabilities (CRPD) is an international treaty and the first of its kind to focus specifically on persons with disabilities. The purpose of the CRPD is to "promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity." (CRPD, Article 1) Furthermore, the CRPD views persons with disabilities as those who have "long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" (CRPD, Article 1).

The CRPD was developed on the basis that persons living with a disability continue to be denied their human rights and are kept on the margins of society across the world despite the numerous human rights treaties already in existence. The CRPD does not create new rights for persons with disabilities, but rather consolidates and amplifies existing human rights and sets out the legal obligations for countries to protect and advance the rights of persons living with a disability.

One of the most significant aspects of the CRPD is that it marks a "paradigm shift" in attitudes and approaches toward persons with disabilities, including persons living with a mental illness. The CRPD fundamentally shifts the view of people with disabilities from "objects" of charity and medical treatment to "subjects" with rights who are capable of claiming their rights and making decisions about their lives based on their free and informed consent, as well as fully participating in society.

This "paradigm shift" reflects a movement away from the medical model of disability and builds upon the social model of disability by including human rights. The medical model of disability refers to a view of disability that focuses on a person's impairment rather than on the person's

social context and environment. This model places emphasis on a clinical and medical diagnosis and views the person as having a problem that needs to be fixed or cured. The social model of disability, on the other hand, views disability as a result of the social context and environment rather than on an individual's impairment. This model places emphasis on the environmental, social and attitudinal barriers that hinder full participation and inclusion by persons living with a disability. In others words, the problem is not that the person needs to be fixed or cured, but rather the problems are discrimination, exclusion and prejudice, and the responsibility lies with society to remove the barriers that hinder a person's full participation in society. The CRPD effectively uses the social model as a basis and adds the critical aspects of human rights as it pertains to people with disabilities.

The CRPD is also a significant departure from how international treaties are negotiated, implemented, monitored, and reported upon. Unlike other treaties, the CRPD has the participation of persons with lived experience as its basis. Several persons with lived experience from Canada contributed significantly to the treaty negotiations and the eventual ratification of the treaty. Furthermore, Articles 4(3), 33 and 35 of the CRPD specifically indicate that persons with disabilities should be consulted, involved and participate fully in the decisions made to implement, monitor and report on the CRPD.

D. Canada's Obligations to Implement and Monitor the CRPD

On March 11, 2010, Canada ratified the CRPD, and in doing so has an obligation to implement the guiding principles and human rights of persons living with a disability and monitor and report its progress. However, in ratifying the CRPD, Canada outlined interpretive declarations and reservations to Articles 12 and 33. With respect to Article 12 – Equal recognition before the law, "Canada recognizes that persons with disabilities are presumed to have legal capacity on an equal basis with others in all aspects of their lives." However, "to the extent Article 12 may be interpreted as requiring the elimination of all substitute decision-making arrangements, Canada reserves the right to continue their use in appropriate circumstances and subject to appropriate and effective safeguards." In making this reservation, Canada is essentially stating that at times it is justified to appoint a substitute decision-maker to make decisions on a person's behalf. It is worth noting, however, that Canada its reservations at any time.

Furthermore, Article 33(2) of the CRPD states:

> *"State Parties shall, in accordance with their legal and administrative systems, maintain, strengthen, designate or establish within the State Party, a framework, including one or more independent mechanisms, as appropriate, to promote, protect and monitor implementation of the present Convention."*

Canada interprets this Article as "accommodating the situation of the federal states where the implementation of the Convention will occur at more than one level of government and through a variety of mechanisms, including existing ones." This essentially means that since Canada is a federation, with powers shared with the provinces and territories, any monitoring

mechanism will need to take that into account. This is especially crucial since many of the rights contained in the CRPD will fall within areas of provincial/territorial responsibility or where there is overlap in responsibility between the federal and provincial governments.

The Committee on the Rights of Persons with Disabilities is a United Nations body of independent experts which has been established to monitor the implementation of the CRPD by the signatory countries. Under Articles 35 and 36, the requirements of reports by States Parties are outlined. All countries that have ratified the CRPD are obliged to submit regular reports to the Committee on how the rights are being implemented. Countries must report initially within two years of ratifying the CRPD and thereafter every four years. When preparing reports, States Parties are "to give due consideration" to Article 4(3) of the CRPD which require countries to "consult with and actively involve persons with disabilities." The Committee reviews each report and will "make suggestions and general recommendations on the report as it may consider appropriate and shall forward these to the country concerned."

It is important to note here that during the course of the Project, the Project Research Team was advised that to date Canada has not yet developed a national plan on how the principles and rights contained in the CRPD will be implemented nor has it designated the independent mechanism that will be responsible for monitoring and reporting on the implementation of the CRPD. Canada has, however, designated the Minister of Canadian Heritage as responsible for coordinating work across jurisdictions on the preparation of the periodic reports to the UN Committee. In addition, the Minister of Human Resources and Skills Development, through the federal Office for Disability Issues, has been designated as the focal point for matters relating to the CRPD at the federal level. This includes promoting coordination across the federal government on disability policy.

E. Human Rights and the Impact on Persons Living with a Mental Illness

Up until the CRPD came into being, the concepts of "human rights" and "mental illness" were not often discussed together in the public forum. The reality is that persons living with a mental illness have historically been, and continue to be, marginalized in society. The "charity model" referred to earlier remains the predominant view of persons living with a mental illness. The awareness and change needed to view all persons as having the same fundamental rights and freedoms is in its early stages.

To demonstrate this point, below is a table that lists in the first column the key principles and rights contained the CRPD. The second column lists the common experiences of persons living with a mental illness provided by members of the Project's Consultation Group. It is not an exhaustive list, but rather is intended to highlight examples of how the principles and rights in the CRPD are not yet reflected in the actual experiences of persons living with a mental illness.

Table 1: The CRPD and Experiences of Persons Living with a Mental Illness

UN Convention on the Rights of Persons with Disabilities	Experiences of Persons Living with a Mental Illness
Principles (Article 3, CRPD)	
(a) Respect for inherent dignity, individual autonomy and independence, and the freedom to make one's own choices	• Respect for the dignity, autonomy and independence of persons living with a mental illness is often not consistently reflected in mental health legislation, policies and standards. • Persons living with a mental illness often feel they are not treated with dignity, autonomy and respect within the mental health service system.

(b) Non-discrimination and equality of opportunity	• Persons living with a mental illness:
	  • experience discrimination in the community, including but not limited to areas such as employment, education, and housing;
	  • experience prejudice, stereotyping and stigma;
	  • at times need assistance, support or accommodation to have equality of opportunity.

(c) Full and effective participation and inclusion in society	• Persons living with a mental illness have historically been, and continue to be, excluded in society and housed in institutional settings apart from the community. • The stigma surrounding mental illness results in persons living with a mental illness being excluded from participation within their communities. • Persons living with a mental illness disproportionately represented among persons living in poverty.
(d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity	• Mental health services do not always respect the diversity among people living with a mental illness and recognize that every person's experience with mental illness is different, particularly the cultural differences in understanding mental illness and supporting/treating a person living with a mental illness. • Persons living with a mental illness are seen as being deficient or that there is something wrong with them rather than being viewed as part of human diversity and humanity.
(f) Accessibility	• Persons living with a mental illness face numerous barriers to accessing the resources needed to lead a meaningful life. This can mean access to needed health and support services as well as access to aspects of the community that contribute to everyone's well-being, such as employment. • Attitudinal barriers such as discrimination and stigma are particularly relevant accessibility issues for persons living with a mental illness.
(g) Equality between men and women	• Gender-based inequality becomes more pronounced when mental illness is a factor. Mental illness has traditionally been viewed in highly gendered ways that affect many aspects of living

UN Convention on the Rights of Persons with Disabilities	Experiences of Persons Living with a Mental Illness
	with a mental illness. • There are gender differences in diagnosis and treatment of mental illness; however mental health services are not consistently gender-appropriate or gender-sensitive.
(h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities	• There is often not a seamless transition from the adolescent to adult mental health system. • The needs of children and youth living with a mental illness require specific consideration.
Rights	
Article 10 - Right to life	• Persons living with a mental illness have an increased likelihood of living in poverty and experiencing physical health problems as a result. Living in poverty is a right to life issue because of its life expectancy-reducing effects. • Persons living with a mental illness have been criminalized or marginalized because of their mental illness, resulting in a lower quality of life. • Persons living with a mental illness have undergone experimental treatment or other treatment that has a life-reducing impact, such as persistent or life threatening side effects from psychotropic medication.
Article 11 - Situations of risk and humanitarian emergencies	• Provincial/territorial emergency or natural disaster plans do not consistently take into consideration the needs of persons living with a mental illness.

Article 12 - Equal recognition before the law	• Current laws:
	  • allow substitute decision-makers to be appointed to make all decisions even though the person living with a mental illness may have capacity to make some or all decisions on their own or with support;
	  • do not promote supported decision-making as an alternative to substitute decision-making.

Article 13 - Access to justice	• People who are admitted to a mental health facility or who live in the community do not always know their legal rights or how to access legal resources. • The court system and the mental health review board system can be intimidating and it is often necessary to have an advocate to help navigate the system; however there is a lack of independent advocates for persons living with a mental illness.
Article 14 - Liberty and security of person	• The right to liberty and security of the person is one of the most contentious in the CRPD for the reason that some people believe that involuntary admission and treatment are necessary in order to prevent harm to the person or others and prevent further deterioration of their illness while others believe that involuntary admission and treatment are rarely,

UN Convention on the Rights of Persons with Disabilities	Experiences of Persons Living with a Mental Illness
	if ever, justified. • In general, involuntary admission has been justified on two grounds: (1) if the person is a danger to him/herself or others; or (2) the person's physical or mental health will substantially deteriorate if he/she is not involuntarily admitted. Some believe broadening the involuntary admission criteria to include both preventing harm and providing treatment violates a person's right to liberty and security of the person because it makes it easier to involuntarily admit and/or treat a person. Others believe limiting involuntary admission to only preventing harm to the person or others violates a person's rights because it prevents timely intervention to ensure a person's physical or mental health does not significantly deteriorate. • It is the view of some that a lack of mental health services and supports in the community is a contributing factor in the deterioration of an individual's mental health, at times leading to involuntary committal and/or treatment. (Linked to Article 25 – Right to Health)
Article 15 - Freedom from torture or cruel, inhuman or degrading treatment or punishment	• For some, the act of forcibly hospitalizing and/or treating someone against their will is a form of torture and cruel treatment. • In some jurisdictions, the use of Electroconvulsive Therapy (ECT) is increasing and persons living with a mental illness are not consistently told of its severe side effects. • Seclusion and restraint practices in mental health facilities are at times used as a form of punishment. Types of restraint include physical, chemical and psychological (the threat of restraint). Some people believe seclusion is never justified and should not be considered as a form of treatment. Some persons living with a mental illness feel like "criminals" when they are restrained. • There is a lack of consistent monitoring of the conditions in mental health facilities and mental health community-based services, the use of restraint and seclusion, and the use of other intrusive procedures.
Article 16 - Freedom from exploitation, violence and abuse	• Persons living with a mental illness are at risk of exploitation, violence and abuse in mental health facilities, in their communities and in their homes. • There is a greater need for gender and age sensitive support for persons living with a mental illness, their families and support networks in instances when exploitation/violence/abuse has occurred.

UN Convention on the Rights of Persons with Disabilities	Experiences of Persons Living with a Mental Illness
Article 19 - Living independently and being included in the community	• Persons living with a mental illness face many barriers to living independently in the community. • Persons living with a mental illness are often not viewed as persons with whole lives, including having families and children, and participating in the community.
Article 20 - Personal mobility	• Persons living with a mental illness who also experience physical challenges that affect their personal mobility require accommodation.
Article 21 - Freedom of expression and opinion, and access to information	• Information related to one's mental health and services are not always culturally-sensitive and available in a person's own language.
Article 22 - Respect for privacy	• There is a lack of privacy when communicating with family, friends and a person's support network while in a mental health facility, for example having a private bedroom, visits in a private space, and telephone access in a private space. • A person's private medical information is at times disclosed without the person's consent, such as in the workplace and to family members.
Article 23 - Respect for home and family	• Parents living with a mental illness have lost custody of their children on the basis of having a mental illness. • Persons living with a mental illness, most particularly women, are often discouraged from having children. • Parents living with a mental illness and parents whose child(ren) have a mental illness require specialized support services.
Article 24 - Education	• Persons living with a mental illness are denied equal access to education programs. • Persons living with a mental illness require support to access and complete education programs.
Article 25 - Health	• Obtaining timely access to necessary health care and mental health services is challenging for persons living with a mental illness. • There is inconsistent follow-up of persons living with a mental illness entering the medical system. • Persons living with a mental illness are often viewed with suspicion and distrust from health care professionals and the pervasive assumptions and stigma need to be addressed. • Health and mental health services are not always located close to a person's community, in particular in rural and remote areas.
Article 26 - Habilitation and rehabilitation	• Some persons living with a mental illness require assistance to achieve success in the social roles of their choosing, for example tenant, student, or employee; however this support is not always

UN Convention on the Rights of Persons with Disabilities	Experiences of Persons Living with a Mental Illness
	available.
Article 27 - Work and employment	• Persons living with a mental illness are often discriminated against and prevented from obtaining employment due to their disability. • Persons living with a mental illness sometimes require reasonable accommodation in order to fulfill the requirements of their job; however employers do not consistently provide accommodation.
Article 28 - Adequate standard of living and social protection	• Persons living with a mental illness often live in poverty and do not have an adequate standard of living. • Disability insurance/pension is very difficult to access for persons living with a mental illness.
Article 29 - Participation in political and public life	• Persons living with a mental illness are not consistently involved in the development of legislation, policies and standards that affect them.
Article 30 - Participation in cultural life, recreation, leisure and sport	• Persons living with a mental illness do not necessarily have access to cultural, recreational, leisure and sport activities in their community due to financial or other restrictions.

IV. PROJECT GOAL AND OBJECTIVES

The link between mental illness and human rights is the subject of this Project. Its premise of the Project is that mental health legislation, policies and services standards provide the framework within which persons living with a mental illness are perceived and included in society. In turn, this framework forms the basis for mental health practice and should be grounded in human rights and the social model of disability.

The primary goal of the Project was to develop and pilot an instrument to measure and evaluate the degree to which human rights are incorporated into existing mental health legislation, polices and service standards in Canada. It is anticipated that the results of the pilot will highlight any gaps between the laws, policies and standards that currently exist and the fundamental human rights of persons living with a mental illness. The results could be used as a catalyst for legislative reform and policy and standards development to ensure the rights guaranteed by the CRPD are protected and upheld. Lastly, the Project Research Team hopes that the development and piloting of an Evaluation Instrument will expedite the process to establish national and provincial mechanisms to implement and monitor the CRPD.
In order to achieve this goal, the objectives of the Project were as follows:

1. To develop an instrument to evaluate the extent to which human rights are addressed in existing legislation, policies and standards as they relate to persons living with a mental illness;

2. To conduct a preliminary assessment of the existing legislation, policies and standards as they relate to persons living with a mental illness;
3. To draft a set of recommendations pertaining to the Evaluation Instrument; legislative reform; and policy and standards development; and,
4. To develop a plan that guides the dissemination of the Evaluation Instrument to federal and provincial/territorial governments, and non-government organizations and promotion of its use as part of the monitoring function of the CRPD in Canada.

V. METHODOLOGY

A. Collaboration and Participation (Input)

The Project Research Team recognized early on that the Project has the potential for considerable impact on persons with lived experience, family members, service providers, non-government organizations, and government. As such, the Project architects and Project Research Team established a Project design with the collaboration and participation of these groups as the central feature.

The Project methodology included three mechanisms for collaboration and participation to occur: 1) Pilot jurisdictions; 2) Stakeholder Groups; and 3) Consultation Group.

1. Pilot Jurisdictions

The Project Research Team recognized at the outset that each province and territory in Canada has its own unique approach to mental health and that efforts to address the treatment, protection and inclusion of persons living with a mental illness would have common elements as well as differences. In an effort to achieve an in depth analysis, assessment, and understanding of existing mental health related legislation, policies and standards, three pilot jurisdictions were chosen as a focus of the Project research: 1) Manitoba; 2) Nova Scotia; and 3) British Columbia. The pilot jurisdictions were chosen based on the criteria set out below.

- Evidence exists to demonstrate that the jurisdiction is actively establishing, reviewing, or reforming mental health legislation, policies and standards;
- Evidence exists that the legislation, policies and standards reflect human rights principles;
- Evidence exists that the legislation differs from one jurisdiction to another and is representative of a different model of mental health legislation; and,
- Evidence exists that the jurisdiction shows interest in becoming involved in the Project.

In addition, it was important to the Project Research Team that as much as possible the Project reflects Canada's diverse geographical regions and interests. In this case, Nova Scotia represents the Maritime interest; British Columbia reflects the Pacific coast interest; and, Manitoba reflects the Prairie province perspective. The Project Research Team acknowledged that the province of Quebec and the northern territories are also critical regions, and in recognizing that this is a pilot project, it is hoped that other provinces and territories will be involved in subsequent phases.

2. Consultation Group

a. Selection Process

The individuals that were sought to participate in the Consultation Group were adults with lived experience; who had some knowledge and experience with the mental health service system including previous involuntary admission to hospital or involvement with the criminal justice system; who had an interest in human rights as related to mental illness; and who were at a stage in their recovery that they could actively participate in the Consultation Group. Additional considerations for the Project Research Team in selecting Consultation Group members were achieving a gender balance in the Group's composition and an urban/rural geographical distribution.

In April 2010 the Project Research Team put out a national call for Consultation Group members. The Canadian Mental Health Association (CMHA) national network was utilized as well as the CMHA provincial/territorial offices in each of the pilot jurisdictions. The CMHA provincial/territorial offices were asked to share the Project information within their networks and provide the Project Research Team with the names of individuals who were interested in participating as a Consultation Group member. Individuals were then asked to apply, and subsequently participated in telephone interviews with the Project Manager.

b. Composition

The Consultation Group members who were selected and who agreed to participate in the Consultation Group consisted of:

- Two persons residing in each of the three pilot jurisdictions;
- One person residing in a northern territory; and,
- One person residing in Quebec.

One of the Consultation Group members was able to bring some of the concerns of northern Aboriginal people to the discussions; however the Project Research Team recognized at the outset the unique needs of Aboriginal people living with a mental illness and acknowledged the essential need for further consultation with First Nations, Métis and Inuit populations.

The Consultation Group member biographies are located in Appendix A of this document.

c. Role and Participation

The role of the Consultation Group was essential to the Project. Throughout the course of the Project and using different means, the Consultation Group members shared their perspectives and experiences on what it means to live with a mental illness and how their rights have been supported and, at times, violated. In particular, the Consultation Group provided detailed guidance and feedback on the Evaluation Instrument developed to evaluate mental health legislation, policies and service standards. Drawing from personal experiences with mental illness and recovery, the members of the Consultation Group provided their opinions, views, and suggestions for changes to the Evaluation Instrument in order that it would most closely resemble and honour the experiences of persons living with a mental illness. A complete description of the role and responsibilities of the Consultation Group can be found in the Terms of Reference located in Appendix B.

The methods of participation by the Consultation Group members included:

- In-person meetings held on three occasions during the course of the Project (July 2010, September 2010, and February 2011);
- Teleconference meetings;
- Three Assignments that facilitated the connection between personal experiences and human rights, as follows:
    - **Assignment #1 Your Story**
      This assignment was provided to members upon their acceptance into the Consultation Group and was due prior to the first in-person meeting held in Winnipeg in July 2010. The assignment required Consultation Group members to share their personal stories and in particular highlight instances when they thought their rights had been infringed. During the meeting in Winnipeg, the Consultation Group members worked with the Project Research Team to draw the connections between their stories and legislation, policies, service standards, and human rights principles.

    - **Assignment #2 Photovoice**
      Photovoice is a method of sharing stories and experiences through photos and words. Following the first in-person meeting of the Consultation Group, the members were asked to take photos that represented their community's strengths and challenges in relation to the human rights of people living with a

mental illness. During the second in-person meeting, members presented 3-5 pre-selected photos to the Group and answered the following questions for each:

What do you see in this photo?
How does the photo make you feel?
What do you think about the photo?
What can we do about the issues raised in the photo?

With the permission of the Consultation Group members, the presentations were audio-taped for the purpose of conducting a thematic analysis of the presentation content. The final photovoice product consists of the photos taken by the Consultation Group members accompanied by their stories told in their voices. This powerful presentation is available for public viewing on the Canadian Mental Health Association – Winnipeg Region's website at www.cmhawpg.mb.ca/MHCCproject.htm.

- **Assignment #3 Your Human Rights Story and Photovoice Assignments Re-visited**
  This assignment required the Consultation Group members to return to Assignment #1 and re-tell their story as if their rights had been respected. This gave the Consultation Group members and the Project Research Team alike an opportunity to learn more about how a person's experience can be entirely different if their human rights are respected.

- An online forum was set up for Consultation Group members to engage in Project related discussions throughout the duration of the Project.

3. Stakeholder Groups

a. Selection Process and Composition

Human rights and mental illness are issues that involve several sectors. As a result, it was recognized early on that there was a need to learn about the context in each jurisdiction by establishing Stakeholder Groups in the three pilot provinces representing key sectors including human rights, legal, government, and non-government, as well as persons with lived experience and family members. Representatives from each of these sectors were invited to participate.

b. Role and Participation

The purpose of the Stakeholder Groups was three-fold: 1) to provide information regarding the existing legislation, policies and standards as they relate to persons living with a mental illness within their respective jurisdictions; 2) to act as an ongoing source of information as the Project

progressed; and 3) to provide direction on piloting the draft Evaluation Instrument within their jurisdiction.

The stakeholders were invited to participate in in-person meetings within their jurisdiction. The meetings followed a focus group format in which pre-determined questions were asked of the participants. Prior to the meeting, participants received the questions that would be asked as well as a description of key human rights as they pertain to persons living with a mental illness. The responses provided during the meeting were anonymously documented for the purpose of analysis. A written summary of the discussion was provided to the participants following the meeting.

Stakeholder Group meetings took place in Nova Scotia (September 2010), Manitoba (November 2010), and British Columbia (February 2011). Individuals who indicated an interest in participating in the Stakeholder Group meeting in their jurisdictions but who were not able to attend were offered the opportunity to participate in an individual discussion with the Project's Principal Researcher.

B. Research Approach (Process and Output)

The approach to meet the Project's objectives involved a step-by-step process and within each step of the process were several activities. It is important to note here that the collaboration with and participation of the pilot regions, Consultation Group, and Stakeholder Groups was a consistent feature within each step and that the input received was continuously incorporated into the research findings and analysis.

Step 1 - Information Gathering

1. Reviewed existing mental health and human rights Evaluation Instruments (International) by conducting a literature search, Internet search, and interviews with authors of existing instruments.
2. Reviewed international human rights treaties, in particular those to which Canada is a signatory.
3. Reviewed existing domestic mental health laws, policies and standards within the three pilot jurisdictions, and others that may be relevant.
4. Conducted focus group and individual discussions with key stakeholders within the three pilot jurisdictions and Ontario.
5. Learned about the experiences of persons living with a mental illness through discussions and exercises with the Project's Consultation Group.

Step 2 – Evaluation Instrument Development

1. Conducted an analysis of the information gathered in Step 1 and combined the findings with the expressed views of the Consultation Group members to form the basis for the

development of an instrument to evaluate mental health legislation, policies and standards with a human rights lens.
2. Presented the draft Evaluation Instrument to the Consultation Group members, and through a small group discussion format, received detailed feedback on each section of the draft instrument.
3. Distributed the draft Evaluation Instrument to the MHCC Evaluation Project Committee for feedback.
4. Incorporated the feedback received from the Consultation Group and the Evaluation Project Committee into the draft Evaluation Instrument.

Step 3 – Assessing Existing Legislation, Policies and Standards

1. Invited organizations that had participated in the stakeholder focus group sessions to volunteer to pilot the Evaluation Instrument within their respective jurisdictions.
2. Conducted training with each of the three organizations that would lead the implementation of the pilot within their jurisdiction. The training session held via video-conference and in-person consisted of a review of the draft Evaluation Instrument, exercises in the use of the instrument, and instruction on the completion of the Evaluation Instrument including the process to gather responses and submit the data.
3. Conducted an analysis of the data received from the pilot sites as it pertained to the effectiveness of the Evaluation Instrument in evaluating the extent to which mental health legislation, policies and standards address human rights.

Step 4 – Recommendations Development

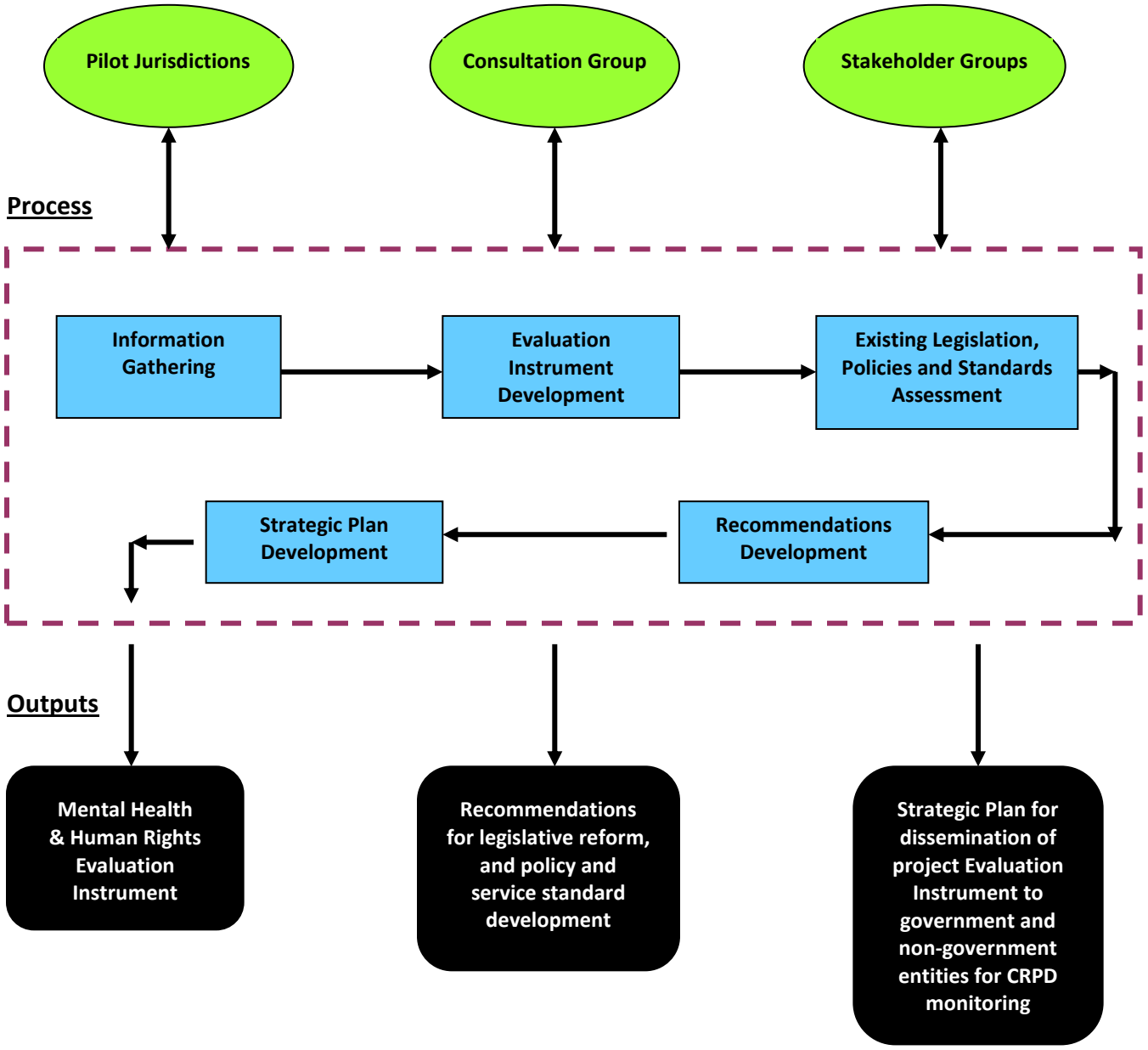
1. Based on the information gathered in Step 1 and the results of piloting the Evaluation Instrument in Step 3, drafted a set recommendations regarding the draft Evaluation Instrument; legislative reform; policy and standards development; and, the implementation and monitoring of the CRPD as it relates to the mental health sector in Canada.

Step 5 – Strategic Plan Development

1. Developed a plan that guides the dissemination of the Evaluation Instrument to government and non-government entities and how it could be used as part of the monitoring function of the CRPD in Canada.

Figure 1 below is an illustration of the research methodology.

Figure 1: Illustration of Research Methodology



VI. FINDINGS

A. Existing Mental Health and Human Rights Evaluation Instruments

Existing mental health and human rights evaluation instruments were reviewed for the purpose of gaining knowledge about the elements that contribute to an effective evaluation instrument. The direction provided by the MHCC Evaluation Project Committee was to examine in particular the Scottish Recovery Index (SRI); Australia's Rights Analysis Instrument (1999); and, the Council of Europe's Recommendation (2004) 10. Subsequently, interviews were conducted with the authors of the instruments, administrators familiar with the instruments, and where possible, mental health advocates or service users familiar with the impact of the instrument on the circumstances of persons living with a mental illness. In addition, individuals were contacted via e-mail and in place of an interview, written responses to the questions were provided.

Scottish Recovery Indicator

In 2006, the Scottish government held a series of open meetings with persons living with a mental illness to learn the impact of legislative and policy developments in the previous six years, such as the principles in the 2003 Scottish Mental Health Act; work on social inclusion including new rights in the 2003 Act; and development of the Scottish Recovery Network. The government was surprised to learn that despite these progressive steps, people continued to experience discrimination and the focus of the discussion was on how poorly they were being treated in society. This led to the development of the Scottish Recovery Indicator (SRI) which is intended as a self assessment tool to be used by those delivering and using services to consider the degree to which those services address inclusion, rights and recovery and to offer a basis for collectively considering changes and improvements to be made. The SRI is being used widely within Scotland and outside of the country. Preliminary evaluation results show that the SRI has good potential to influence change at the service level but change at the system level is yet unknown.

Rights Analysis Instrument

The Rights Analysis Instrument (RAI) was developed by the Human Rights Branch, Attorney General's Department in Canberra, Australia for the purpose of assessing the status of existing mental health legislation and the likely impact of proposed new legislation or amendments. It was proposed that the RAI be used for the purpose of annual reporting on legislative reform and was designed to measure compliance by State and Territory legislation with:

- the United Nations (UN) Principles for the Protection of and for the Improvement of Mental Health Care, passed by a resolution of the General Assembly in December 1991; and
- the National Mental Health Statement of Rights and Responsibilities which

was drafted by the Mental Health Consumer Outcomes Task Force and adopted by Australian Health Ministers in March 1991.

It was anticipated that measurement would enable an objective evaluation to be made of existing reforms to State and Territory mental health legislation in terms of their responsiveness to these obligations.

The RAI was applied to seven out of eight jurisdictions in Australia and was deemed to be a success in aligning mental health legislation with human rights; however criticisms included the lack of participation of a range of individuals in the evaluation process; the wording in the document was considered to be too technical; and, the tool focused on provisions rather than the transfer of law into practice.

The RAI has been used infrequently over the last five years due to the reasons that the UN Principles for the Protection of and for the Improvement of Mental Health Care (1991) are now superseded by the CRPD, and Australia has 'moved on' from the analysis of law and human rights to transferring these concepts into practice.

Council of Europe Recommendation (2004) 10

The Steering Committee of the Bioethics Division, Council of Europe led the development of *Recommendation (2004)10 (Recommendation)* with the purpose of promoting better protection of the human rights and dignity of persons with mental disorder. The *Recommendation* is essentially a set of guidelines to "enhance the protection of the dignity, human rights and fundamental freedoms of persons with mental disorder, in particular those who are subject to involuntary placement or involuntary treatment."

In 2009, the Steering Committee on Bioethics distributed a questionnaire to the delegations to obtain information on the implementation of the *Recommendation's* provisions and on any practical and structural difficulties encountered in implementing the provisions. Responses were received from twenty-six delegations. In summary,

- Seventeen delegations stated that they have revised their legal frameworks since the adoption of the *Recommendation*. Some of these revisions involved drafting new legislation, while others consisted of amending existing legislation. The revisions related in particular to changing the criteria for involuntary placement and adopting the relevant procedural provisions (appeal facilities and automatic review of placement decisions).

- Eight delegations stated they had revised professional standards since the adoption of the *Recommendation*. These revisions involved adopting recommendations on the diagnosis and treatment of aggressive behaviour with a view to minimizing incidents of involuntary placement and treatment by prioritizing less invasive types of treatment, as well as rules on improving mental health service quality.

- Seven delegations acknowledged that the *Recommendation* served as a reference for the revision of the legal framework and/or of professional standards. One delegation pointed out that the new legislation incorporated several provisions of the *Recommendation* in their entirety. Another delegation stated that the Recommendation, which was still under preparation at the time of the revision of its national legislation, nonetheless served as a reference for the latter.

- Further revision of the legal framework is scheduled or under way in seven States. One delegation specified that the *Recommendation* will be taken into account when its framework is revised. (Council of Europe, 2011)

Critics of the *Recommendation* believe its development was "medically driven" and that persons living with a mental illness were not sufficiently consulted. Furthermore, the *Recommendation* is perceived by some as promoting the separation between persons living with a mental illness and persons who are not, with an emphasis placed on restricting rights based on the presumption that persons living with a mental illness are 'dangerous to others'. In focusing on treating persons living with a mental illness against their will, the *Recommendation* appears to favour protecting society over protecting the individual rights of persons living with a mental illness.

B. International Law

Several international treaties, covenants and declarations were reviewed for the purpose of conducting a cross-analysis with the CRPD. The purpose of this exercise was to ensure that all of the key rights as they relate to persons with disabilities were addressed in the CRPD and that no additional rights beyond those contained in the CRPD would need to be included in the Evaluation Instrument developed. The international treaties, covenants and declarations reviewed included the following:

- UN Universal Declaration of Human Rights
- UN Declaration on the Right to Development
- UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care
- UN Convention on the Elimination of All Forms of Racial Discrimination
- UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities
- UN Convention on the Elimination of All Forms of Discrimination against Women
- UN Convention on the Rights of the Child
- UN International Convention on Civil and Political Rights
- UN International Convention on Economic, Social and Cultural Rights
- UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- ILO Convention on Vocational Rehabilitation and Employment (Disabled Persons)

- Vienna Declaration and Programme of Action
- Sundberg Declaration
- Salmanaca Statement on Special Needs Education
- African Charter on Human and Peoples' Rights
- African Charter on the Rights and Welfare of the Child
- Inter-American Convention on the Elimination of all forms of Discrimination against Persons with Disabilities
- Council of Europe Convention on Human Rights and Biomedicine
- Council of Europe Recommendation 1235 (1994) on psychiatry and human rights
- European Convention for the Protection of Human Rights and Fundamental Freedoms
- Protocol No. 4 to the European Convention for the Protection of Human Rights and Fundamental Freedoms
- European Social Charter
- American Convention on Human Rights
- Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights

The analysis showed that all of the guiding principles and specific rights found in the CRPD are referenced to varying degrees in the above international treaties, covenants and declarations. They are recognized internationally as fundamental principles and inalienable human rights that are shared by all. Furthermore, some of the documents expressly recognize that the needs of particularly vulnerable groups, including children, women and persons living with a mental illness, warrant special consideration so their rights will be respected.

C. Provincial Mental Health Legislation, Policies and Standards

The Project Research Team reviewed existing mental health legislation, policies and standards in the three pilot provinces, namely: British Columbia, Manitoba, and Nova Scotia. A comparative analysis was conducted across the three jurisdictions which revealed both consistencies and significant differences in each of the areas of legislation, policies and standards.

1. Legislation

From the beginning of the review process, it was recognized that there are potentially several pieces of legislation within any jurisdiction that can have an impact on persons living with a mental illness. For example, there are laws that relate specifically to the protection of persons in care; sub-populations such as children and youth through child protection legislation; and within the broader population such as human rights legislation. There are also separate pieces of legislation that address key aspects of mental health treatment and care such as the *Health Care Consent Act* (British Columbia) and *Incompetent Persons Act* (Nova Scotia), as well as legislation that addresses the social determinants of health, such as legislation related to housing and employment.

However, for the purpose of analysis and comparison across jurisdictions, it was important to examine legislation that specifically applies to persons living with a mental illness. That being said, the mental health laws examined from the three pilot provinces were the following:

The Mental Health Act (Manitoba)
Mental Health Act (British Columbia), and
Involuntary Psychiatric Treatment Act (Nova Scotia)

Key findings from the review and cross-analysis include the following:

Purpose of the Legislation

- Only Nova Scotia's legislation contains a purpose section that sets out the intent of the law. A number of the guiding principles expressly mentioned in this provision are relevant to the human rights of persons living with a mental illness, for example:
  - persons of all ages with mental disorders are entitled to be treated with dignity and respect;
  - each person has the right to make treatment decisions to the extent of the person's capacity to do so;
  - treatment and related services are to be offered in the least restrictive manner with the goal of having the person continue to live in the community or return to the person's home surroundings at the earliest possible time;
  - the primary mode of admission to a psychiatric facility should be as a voluntary patient where possible;
  - treatment and related services, where possible, should promote the person's self-determination and self-reliance;
  - the person has the right to a treatment plan that maximizes the person's potential and is based on the principles of evidence-based best practice;
  - persons with mental disorders should have access to mental health services as close as possible to the person's home as practicable; and
  - any declaration of involuntary admission or declaration of incapacity is made on the basis of evidence.

Definitions

- All three provinces define “mental disorder” in a way that reflects the medical model of disability. The definition of “mental disorder” includes a reference to treatment in both BC's and Nova Scotia's legislation, but not in Manitoba's. Nova Scotia's definition of “mental disorder” states that it is a disorder “in respect of which psychiatric treatment is advisable”. BC's definition states it is a disorder that “requires treatment”.
- Manitoba's legislation is the only one that expressly defines the term “restraint” and defines it as “to place under control when necessary to prevent harm to the patient or to another person by the minimal use of such force, mechanical means or medication as

is reasonable having regard to the patient's physical and mental condition".

- BC's legislation is the only one that expressly defines the term "treatment" and defines it as "safe and effective psychiatric treatment and includes any procedure necessarily related to the provision of psychiatric treatment".

Deprivation of Human Rights

- Nova Scotia's legislation is the only that expressly prohibits deprivation of human rights. Section 64 states: "A person detained under a certificate of involuntary psychiatric assessment, a patient admitted to a psychiatric facility by a declaration of involuntary admission or a patient subject to a CTO must not be deprived of any right or privilege enjoyed by others by reason of receiving or having received medical health services, subject to those rights prescribed by regulation."

Voluntary/Involuntary Admission

- All three jurisdictions have provisions relating to voluntary admission to a mental health facility.
- All three jurisdictions have separate provisions relating to involuntary admission to a mental health facility, including renewal certificates.
- There are slight differences in the wording of the involuntary admission criteria. Manitoba's legislation permits involuntary admission if the person has a mental disorder, is in need of treatment and is <u>likely</u> to cause serious harm to him/herself or to others or to suffer substantial physical or mental deterioration. Nova Scotia's legislation permits involuntary admission if the person has a mental disorder, is in need of treatment and <u>is or has recently been threatening or attempting to cause</u> serious harm to him/herself or others or is <u>likely</u> to suffer both serious physical impairment and/or serious mental deterioration. BC's legislation permits involuntary admission if the person has a mental disorder, <u>requires treatment or requires care, supervision and control in a facility to prevent</u> the person's substantial mental or physical deterioration or for the protection of the person or others.

Capacity and Consent

- Nova Scotia's legislation is the only jurisdiction out of the three that does not contain an express presumption of capacity; however ss. 52(1) and 54 (1) in Nova Scotia's Hospitals Act does refer to an express presumption of capacity and consent.
- Both Manitoba and BC recognize 16 as the age upon which capacity to make treatment decisions is presumed.
- There are significant differences between the legislation in Nova Scotia, Manitoba and BC with respect to capacity and consent in the context of treatment decisions by persons who are involuntarily admitted to a mental health facility. In particular:
  - In Manitoba, involuntary admission to a mental health facility does not depend on

whether a person has the capacity to make treatment decisions. If a person is involuntarily admitted and has the capacity to make treatment decisions, then unless it is an emergency, no treatment can be given without the person's consent. If the person does not have the capacity to make treatment decisions, then unless it is an emergency, treatment cannot be given without the consent of the person authorized to make treatment decisions on their behalf. The individual authorized to make treatment decisions must do so in accordance with the person's prior expressed wishes when competent, or if their wishes are not known, then in the person's best interests. If the treating physician does not agree with the substitute decision-maker's decision, then the physician may apply to the Mental Health Review Board for an order permitting the treatment to be given. In that situation, the Mental Health Review Board may order the treatment be given, but must first consider whether the person expressed any prior competent wishes and whether in these particular circumstances the person would have altered those wishes if he/she was competent to do so. Similarly, if the individual authorized to make treatment decisions makes a decision that is contrary to a person's health care directive, then the person may apply to the Mental Health Review Board for an order requiring the physician to comply with his/her wishes. The Mental Health Review Board must order the person's wishes to be respected unless it is not in his/her best interests and the person would have, given the circumstances, alter their expressed wishes if he/she was competent to do so.

- In Nova Scotia, a person may only be involuntarily admitted to a mental health facility if he/she meets the admission criteria and does not have the capacity to make treatment decisions. Treatment decisions are made by the person's substitute decision-maker and the psychiatrist is responsible for obtaining the necessary consent before treatment can be given. The substitute decision-maker must make decisions in accordance with the person's prior wishes, unless it would endanger the health or safety of the person or another, or that are in the person's best interests if their wishes are not known. If a physician does not agree with the decision made by the substitute decision-maker, then the physician may apply to the Mental Health Review Board. The Board will not decide whether the treatment should be given, but instead will only consider whether the substitute decision-maker rendered capable informed consent and if not, then the Board will appoint the next suitable decision-maker.
- In BC, a person who is involuntarily admitted to a mental health facility is deemed to have consented to treatment decisions made by the director, regardless of whether the person has capacity to make treatment decisions. The patient or their substitute decision-maker may, within certain specific times, request a second medical opinion if they do not agree with the director's decision. The director only has to consider the second medical opinion and whether changes should be made to the treatment plan.

- Both Manitoba's and Nova Scotia's legislation allow an individual to be authorized to

make treatment decisions on behalf of a person who does not have capacity to consent to or refuse treatment. Only Manitoba's legislation includes provisions relating to the formal appointment of a committee by the director or a court if a person is found to be incompetent to make property and/or personal care decisions. BC and Nova Scotia address the appointment of committees in separate legislation.

Certificates of Leave/Community Treatment Orders

- All three provinces allow for certificates of leave to be issued for patients who have been involuntarily admitted to a mental health facility. The purpose of a certificate of leave is to allow the patient to leave the facility and live in the community, provided the necessary services are available and will be provided. Although the wording in the legislation differs slightly, in general certificates of leave are for a period of up to six months but they can be renewed. The certificate of leave in general must set out the treatment plan and any conditions the person must comply with. If the person does not comply with the treatment plan and/or the conditions, the certificate of leave may be cancelled and that will give the police the authority to pick up the person and return him/her to the mental health facility for an assessment. Certificates of leave can only be issued with the consent of the person or the person's substitute decision-maker.
- Only Nova Scotia's legislation provides for Community Treatment Orders to be issued so that an individual who would otherwise be involuntarily admitted can live and receive treatment in the community. From the wording of the legislation, the primary difference between a certificate of leave and a Community Treatment Order is that a certificate of leave applies to persons who have been involuntarily admitted to a mental health facility, while Community Treatment Orders apply to persons who are living in the community and have not been involuntarily admitted. Also of note is that Nova Scotia's legislation requires a review of the Community Treatment Order provisions during the 6th year after they came into force. The Minister must make the written report of the review available to the public and also table it in the House of Assembly.

Patient's Rights

- Only Nova Scotia's legislation establishes a Patient Advisor to inform persons in a mental health facility about their rights, for example when undergoing an involuntary psychiatric assessment or when they are involuntarily admitted to a mental health facility. In addition to providing information, the Patient Advisor is also able to assist persons in a mental health facility with making an application to the Review Board and to obtain legal counsel. The legislation also requires the Patient Advisor be given notice when an application to the Review Board has been made regarding an involuntary patient.
- BC's legislation expressly requires patients detained in a mental health facility to be informed orally and in writing of their rights in s. 10 of the *Charter*. Both Manitoba's and Nova Scotia's legislation requires involuntary patients to be informed in writing of their

right to retain and instruct counsel.

Mental Health Review Board

- All three laws establish a mental health review board (Review Board) that includes provisions relating to the jurisdiction of the board and appeal procedures.
- Both Manitoba's and Nova Scotia's legislation expressly permit the review of treatment decisions to the Review Board.
- Both Manitoba's and Nova Scotia's legislation expressly state that a party may appeal an order of the Review Board to a court. BC's legislation does not expressly contain provisions relating to appeals of the Review Board's decisions to a court, however it does make reference to relevant provisions of *The Administrative Tribunal Act*.
- Both Manitoba's and Nova Scotia's legislation expressly state that a person may be represented by counsel or an agent at a Review Board hearing. BC's legislation does not expressly include such a provision, although it does make reference to relevant provisions of *The Administrative Tribunal Act*.
- Nova Scotia's legislation is the only one to require the Review Board appoint a representative to attend the hearing and act on the patient's behalf if the patient is unwilling or unable to attend and has not appointed someone else to act on his/her behalf.
- All three provinces require mandatory reviews by the Review Board in certain circumstances. For example, Manitoba's legislation states that an involuntary patient is deemed to have applied to the Review Board after a third renewal certificate has been issued and annually thereafter.

Access to Personal Health Information

- Only Manitoba's *Mental Health Act* expressly sets out provisions relating to accessing personal health information and records. BC and Nova Scotia address this in separate legislation.

Accountability

- Manitoba's and BC's legislation include express provisions detailing what constitutes an offence and the applicable penalties.
- Only Nova Scotia's legislation requires an independent review of the legislation after a period of time. Nova Scotia is currently in the process of conducting such a review.

2. Policies

Mental health policies (also referred to as strategies or action plans) can be developed at the facility or organization level, the regional level and the provincial/territorial level. Policies developed at the provincial/territorial level are intended to impact all mental health services

and programs within the province/territory, while facility/organization and regional level policies are facility, service or region specific.

The Project Research Team examined the mental health policies in each pilot jurisdiction and found that, for the most part, mental health facilities have a set of policies that primarily direct staff behaviour; regions or Regional Health Authorities have policies directing mental health services in their respective regions; and, BC and Manitoba have a range of different provincial policies, while Nova Scotia has no provincial mental health policies. Common across all three jurisdictions was the absence of coordination among the facility, region and provincial policies developed. For example, what one facility or region developed as a policy was not necessarily consistent with another's. Furthermore, the policies were not necessarily connected with the provincial/territorial mental health legislation. Rather, they appeared to be developed in reaction to emerging issues. The result is a myriad of policies for service users to navigate.

It was also found that policies at the facility or regional level are not easily obtained. Provincial mental health policies can be found on a government's web-site, although they are not necessarily grouped together under a common term such as 'policy'. Using a key word search is one means in which to locate the policies on-line. The facility or regional level policies are a different matter. Requests were made to selected mental health facilities and Regional Health Authorities in all three pilot jurisdictions for their mental health policies. Very few sets of policies were forthcoming. The reason most frequently given was lack of time to devote to such an activity. Some did not respond, and the reason for the non-response it unknown. An exception was Selkirk Mental Health Centre in Manitoba, which provided a full set of their facility's policies. The difficulties in obtaining facility and region based mental health policies begs the question of how difficult it might be for a person or family member accessing the service to learn of the policies that affect them.

It was not within the scope of this Project to analyze every facility and regional mental health policy across all three jurisdictions; however the Project Research Team did examine the mental health policies at the provincial level based on the assumption that provincial level policies provide direction to all facilities and regions province-wide, and they would establish the overall vision and direction to be taken into account in mental health service delivery.

As mentioned earlier, Nova Scotia does not have mental health policies at the provincial level; however at the time of this report, Nova Scotia's provincial government was in the process of developing a provincial mental health strategy. On the other hand, BC has several provincial mental health policies. A partial listing of these policies, starting from the most recent, is as follows:

- *Healthy Minds, Healthy People – A 10-year Plan to Address Mental Health and Substance Use in British Columbia (November 2010)*
- *Strong, Safe, and Supported – A Commitment to BC's Children and Youth (April 2008)*

- *Mental Health & Addiction Services for Children, Youth & Adults with Developmental Disability (March 2007)*
- *Addressing Perinatal Depression: A Framework for BC's Health Authorities (July 2006)*
- *Guide to the Mental Health Act: 2005 Edition (April 2005)*
- *Every Door is the Right Door – A British Columbia Framework to Address Problematic Substance Use and Addiction (May 2004)*
- *Child and Youth Mental Health Plan (February 2003)*
- *FASD: A Strategic Plan for British Columbia (2003)*
- *British Columbia`s Provincial Depression Strategy (October 2002)*
- *A Provincial Anxiety Disorders Strategy (April 2002)*
- *Guidelines for Mental Health Care Planning for Best Practices for Health Authorities (February 2002)*

Manitoba has provincial mental health policies, and like BC, they address a range of issues. During the latter stages of this Project, the government of Manitoba released its provincial mental health strategy; however it was too late to include the strategy in the overall analysis. Manitoba's provincial mental health policies beginning with the most recent include:

- *Rising to the Challenge: A strategic plan for the mental health and well-being of Manitobans (June 2011)*
- *Reclaiming Hope: Manitoba's Youth Suicide Prevention Strategy (December 2008)*
- *Order of Committeeship Issued by the Director of Psychiatric Services (January 2008)*
- *Provincial Policy for Service to Individuals with Co-occurring Mental Health and Substance Use Disorders (February 2007)*
- *Family Member and Natural Support Participation in Mental Health Service Planning, Implementation and Evaluation (May 2005)*
- *Consumer Participation in Mental Health Services Planning, Implementation and Evaluation (October 2003)*

It is evident by the range of issues addressed that policies are created based either on an internal or external demand for direction on a particular issue. Although the sheer number of policies in each jurisdiction does not necessarily reflect the effectiveness of mental health services, the fact that there are policies does indicate that there is some level of provincial guidance and accountability in the provision of facility and regional mental health services. The fact that all three jurisdictions do or will have provincial mental health strategies indicates that there is some level of commitment from government to improve mental health services within their respective jurisdiction. As all three strategies are recently developed, it remains to be seen if in fact their goals have been met.

3. Standards

Provincial standards for mental health service delivery are not as common as provincial mental health policies. Among the three pilot jurisdictions, Nova Scotia has a set of provincial mental

health standards; BC has standards for specific mental health services such as Assertive Community Treatment (ACT) Teams and Early Psychosis Intervention Programs as well as several guideline documents; and, at the time of this report, Manitoba was in the process of developing guidelines regarding public education for suicide prevention, hospital admission and discharge protocols for at risk youth, and ethno-cultural competency guidelines for Regional Health Authorities.

The pilot provinces tend to rely on Accreditation Canada's mental health standards as the guide post for mental health service standards; however it is important to note that participating in an accreditation process based on these standards is voluntary and there is no report back or accountability to provincial governments regarding the accreditation other than notification that the facility or service has or has not been accredited. The details of the extent to which facilities meet standards are not shared outside of the facility/organization and Accreditation Canada.

Similar to mental health policies, mental health service standards can be developed at the facility level, regional level or provincial/territorial level, and there is not necessarily any consistency among the standards. Most importantly, there is no consistent monitoring by any one body to ensure that the standards are being met. Accreditation Canada does measure whether progress is achieved in meeting their standards, but as previously stated, the service's ability to meet or not meet the standards is not communicated to the government that largely funds the service.

D. Stakeholder Focus Group Sessions

Stakeholder focus groups sessions were conducted in each pilot jurisdiction for the purpose of gathering information regarding existing provincial mental health legislation, policies and standards; existing bodies/organizations to monitor and ensure that the rights of persons living with a mental illness are protected; the realization and challenges regarding specific rights for persons living with a mental illness; and the degree of receptiveness in each province to human rights as it relates to persons living with a mental illness. The specific rights were taken from the CRPD and identified by the Project Research Team beforehand, and included: access to justice; liberty and security of the person; freedom from torture or cruel, inhuman or degrading treatment or punishment; living independently and being included in the community; and, access to the highest attainable standard of physical and mental health treatment and services. For a definition of each right, refer to the Stakeholder Focus Group Questions located in Appendix C.

One stakeholder focus group session was held in each of the three pilot jurisdictions. If stakeholders could not attend the focus group session, they were invited to participate in individual interviews. The participating stakeholders represented key sectors including human rights, legal, government, and non-government, as well as persons with lived experience and family members.

The format of each session was the same and included an overview presentation of the Project's goal, objectives and methodology as well as anticipated outcomes. A set of questions was posed to each group and a round table method was used to learn the responses of each participant to the questions asked. (Refer to Appendix C for the Stakeholder Focus Group Questions) What follows is a summary of the major points raised by the focus group participants in each jurisdiction in response to the questions asked. **The summary of responses provided by the focus group participants is not meant to be a thorough analysis of the issues, but rather represents the key points as identified by the participants.**

1. *Nova Scotia*

a. Existing Mental Health Legislation, Policies and Standards

Legislation

- There are components relevant to persons living with a mental illness in many pieces of legislation in Nova Scotia. Examples cited were victims' rights, social assistance, and the Services for Persons with Disabilities Program that classifies the level of care an individual needs and relates to housing and income assistance.
- As a result there is confusion among stakeholders and the public alike regarding the legislation that currently exists.
- Addressing all issues affecting persons living with a mental illness within one piece of legislation is difficult. This raised the question as to whether there ought to be separate mental health legislation or whether all issues should be included under the umbrella of health legislation in general. On one hand, including mental health services as part of health legislation in general might reduce stigma. On the other hand, if there is no separate mental health legislation, then there is a risk that mental health services will be ignored.

Policy

- Each District Health Authority generates its own policies around mental health care. There are some policies regarding community mental health services, but most are directed to the care and management of individuals in in-patient settings.
- District mental health policies are not consistent across regions because of the different ways the health districts are organized. However, each District Health Authority attempts to create policies that are consistent with the provincial standards.
- The differences among district mental health policies can be attributed to the availability of resources. Policy is shaped by the resources available rather than on the ideal of how a service is to be provided.
- There is a provincial committee called "OP3": one province, one process, one policy, which includes representatives from the District Health Authorities. The Committee's mandate is to increase efficiency in policy development. Going forward they want all

policies to have the same look and feel across the province (i.e. common template, definitions, procedures, etc.). They are also working towards developing more policies at the provincial level applicable across the province.

Standards

- Provincial mental health standards were released in 2003. Each health district is required to conduct a self-analysis to determine if the standards have been met.
- The Nova Scotia Auditor General's 2010 report criticized the standards as not being objective or easily measurable. The report reviewed four districts in the province and found that all of them fell short of the standards. The Auditor General said that if the province is going to adopt standards, then they must be met. The Auditor General did not audit all of the standards and there is currently a review process underway to make sure the standards are clear and succinct and can be measured. It was noted, however, that standards cannot be measured without the proper data collection and reporting systems in place.
- It was further noted that without additional resources designated for mental health services, it will be very difficult to meet the current standards.
- Nova Scotia's mental health standards are not necessarily human rights based and are fairly pragmatic; for example, there must be an out patient clinic, there must be a diagnosis, etc. The standards do, however, address aspects of human rights such as wait times for services, which is relevant to the right to access mental health services.

b. Existing Monitoring Bodies/Organizations

- There is no mechanism at the provincial level to review or analyze complaints made by mental health service users. Similarly, there is no tracking of complaints to identify trends.

Ombudsperson

- The Ombudsperson accepts and hears complaints from mental health service users in Nova Scotia.
- The Ombudsperson's office received about 2,000 complaints last year; however they do not keep statistics on how many of those complaints related to mental health issues or services.
- The Ombudsperson's office has the authority to initiate its own investigation, for instance if they notice a trend or systemic issue. They have conducted investigations relating to persons living with a mental illness, but for confidentiality reasons they generalize the complaint in their annual report.
- Staff from the Ombudsperson's office routinely visit care facilities for youth and seniors and also visit custodial and licensed facilities, for example group homes. However, the Ombudsperson's office does not visit adult psychiatric facilities on a regular basis.

Nova Scotia Human Rights Commission

- The Nova Scotia Human Rights Commission receives complaints related to mental health and approximately 50% of the complaints received are disability related.
- The Nova Scotia Human Rights Commission has been involved in the Mental Health Peer Advocate Project to establish mental health advocates and a resource manual to assist persons living with a mental illness to navigate the mental health system.

Protection for Persons in Care

- Nova Scotia has a Protection for Persons in Care office under the Department of Health's Monitoring and Compliance Section as well as a new team with the Department of Community Services that are responsible for the protection of persons in care.

Patient Advisor

- The Patient Advisor Service provision under the *Involuntary Psychiatric Treatment Act* (IPTA) involves meeting with people who are admitted involuntarily to mental health facilities. The Patient Advisor informs the person of their rights, and takes applications for Legal Aid or refers the individual to Legal Aid. The Patient Advisor is not an advocate, is not allowed to give legal advice, and can only provide information under the IPTA.

Mental Health Review Board

- The Mental Health Review Board does not monitor mental health facilities. However, the IPTA requires the Review Board automatically review an individual's circumstances after a specific period of time. The Review Board does issue annual reports and does provide written reasons for their decisions.

Hospital-based

- Complaints about the quality of services provided in a hospital may be made directly to the hospital. The Capital Health Authority has a patient representative to assist patients with making a complaint about the care they received. The patient representative will try to resolve the complaint, but since that person is a hospital employee and is not independent, there is a concern about the independence and effectiveness of this complaint process.
- Complaints may also be made to the unit manager or CEO of a hospital, but in smaller areas they may be one and the same person. Often the risk manager of a smaller hospital may be the CEO or unit manager so there is an inherent conflict in that process.

Professional Associations

- Patients who feel they have been mistreated may also file a complaint with Nova Scotia's College of Physicians or College of Nurses or other professional bodies. These bodies are not proactive but are reactive because they only get involved if a complaint is made.

Non-government Organizations

- The Nova Scotia Schizophrenia Society does monitor the provision of mental health services, for example wait times. They have been vigilant about monitoring and there is information on their website.

c. Realization of Human Rights

Access to Justice

- There exists a misperception that going to the Review Board will make a person's situation worse for fear that the doctor will treat them differently.
- Hearings before the Review Board are not recorded and it is therefore difficult to have a proper judicial review if the matter goes to court.

Liberty and Security of the Person

- There is a fundamental debate between the protection of society and individual rights.
- There are times when law enforcement officials are reluctant to take a person to hospital for a mental health assessment as the wait times can be excessive and this takes away from their other policing duties. In some cases, individuals are charged and held in police custody to wait for a mental health assessment rather than going to the hospital.

Freedom from Torture and Cruel Treatment or Punishment

- Issue was not addressed during the focus group discussion.

Living Independently in the Community

- There is a lack of mental health resources in the community which negatively impacts a person's ability to live independently.
- A lack of affordable housing is a major problem that prevents a person from living independently.

Access to Physical and Mental Health Treatment and Services

- There is limited access to physicians and psychiatrists in rural areas.
- About one-half of psychiatric hospital beds are occupied by individuals that could be living in the community either independently or with supports, however these supports do not exist.
- There is a lack of mobile crisis services in rural areas and in urban areas the services operate on a limited basis.

d. Human Rights Environment

Expansion vs. Restriction of Human Rights

- There is limited funding for mental health services, and the funding is primarily targeted to inpatient services rather than community-based services. There are far fewer dollars dedicated to mental health promotion, prevention, and recovery. Funding is needed from multiple sectors in addition to the health sector.
- The *Involuntary Psychiatric Treatment Act* (IPTA) expands the criteria for involuntary admission to hospital and introduced Community Treatment Orders, neither of which is in line with human rights principles.
- The IPTA does not impose positive obligations on government to expand the availability of community-based mental health resources and to address the need for more housing.

Recent Events

- The Hyde Inquiry Report was released in December 2010 and contains over 80 recommendations in response to the death of a man in jail who was known to have a mental illness.

Current Initiatives

- Although the emphasis remains on inpatient treatment, there are some initiatives focused on the prevention of mental illness, such as school-based programs.
- When efforts have been made in the past to close hospital beds, there has been public outcry in fear that community resources will not be expanded simultaneously to respond to the increased need.

2. *Manitoba*

a. Existing Mental Health Legislation, Policies and Standards

Legislation

- There are many pieces of legislation in addition to *The Mental Health Act* that have an impact on persons living with a mental illness, including: *The Protection for Persons in Care Act; Vulnerable Persons Act; Personal Health Information Act*, and others.

Policy

- Mental health policies at facility and regional levels are less widely known than mental health legislation. People may be aware of mental health legislation, but not with the policies at various levels.
- The development of policies is a long-term process and guidelines are often developed instead.
- Some policies are program-specific as opposed to applying to the entire health authority. The policies are also not necessarily consistent across levels within a Regional Health Authority.

- In addition to policies there are cross-departmental protocols that dictate how different departments collaborate and communicate on common issues; for example the protocol between the Departments of Justice, Family Services and the Winnipeg Regional Health Authority.

Standards

- At the time of the session, there was a noted absence of mental health service standards in Manitoba. Instead, the standards from Accreditation Canada were noted as the standards followed by each Regional Health Authority. It is a provincial government requirement that each Regional Health Authority in Manitoba be accredited.

b. Existing Monitoring Bodies/Organizations

- There is no one mechanism at the provincial level that consistently monitors mental health facilities and services.

Ombudsperson

- The Manitoba Ombudsperson is an independent officer and can make recommendations to the Legislative Assembly. For the most part, the office tries to mediate solutions with organizations and achieve the desired ends. The Ombudsperson has the ability to take her own initiative on broader issues where complaints or reviews are more frequent and they are usually reported in an annual or special report.

Manitoba Human Rights Commission

- The Manitoba Human Rights Commission is individual complaints-driven for the most part. The numbers of complaints received that are mental health related are relatively low, and are not considered to be an accurate barometer of the experiences of persons living with a mental illness.
- The Manitoba Human Rights Commission can initiate a complaint that may give a broader overview of an issue; however this mechanism is rarely used because it requires a much higher standard to initiate this type of complaint. The Commission has to have sufficient information in advance to justify filing the complaint.

Mental Health Review Board

- Manitoba's Mental Health Review Board hears individual appeals but does not conduct a proactive monitoring role of mental health services.

Non-government Organizations

- The Canadian Mental Health Association (CMHA) – Winnipeg Region office has a Rights Consultant who advocates with, and not behalf of, persons living with a mental illness. The Rights Consultant works with the person to bring their issue forward, for example to the Human Rights Commission or to the Regional Health Authority.

- The CMHA-Winnipeg office will undertake systemic advocacy when several common issues are brought forward, such as issues related to housing. CMHA as well as other mental health non-government organizations will raise common issues to the provincial government.

Professional Associations

- It was noted that one of the most significant challenges is bringing forward complaints to professional organizations such as the College of Physicians and Surgeons. Some people believe the complaints process is cumbersome and exacerbates existing challenges for individuals already struggling with their mental illness.

c. Realization of Human Rights

Access to Justice

- Appeal processes are often complex and do not necessarily take into account the circumstances of persons living with a mental illness. The result is that persons in prison or in a mental health facility may end up being detained longer than is necessary.
- Persons who are not eligible for provincial/territorial legal aid plans may find it very challenging to locate and acquire legal representation. A legal representative or advocate could assist an individual to navigate the system.
- A proposal for a Mental Health Court has been initiated by the provincial government to provide a means for individuals living with a mental illness to address their underlying mental health problems that have contributed to their criminal behaviour.
- The effectiveness of Mental Health Courts is debatable when, like in Nova Scotia, the court cannot order that resources be made available to support the person in the community when these resources are limited or not available.
- Police training that assists officers to recognize mental illness and respond appropriately is an important factor in ensuring that a person receives appropriate assistance.

Liberty and Security of the Person

- Individuals are not consistently informed about their rights, such as the right to access their medical records, when they engage with a mental health service.
- There is a need for information regarding rights to be communicated in a culturally sensitive manner and in the person's spoken language.
- There is a perception by some that advance directives can be over-ridden by a psychiatrist once the person is deemed to lack capacity to make their own decisions. The law does in fact allow for psychiatrists to apply to the Review

Board when treatment has been refused and the psychiatrist wishes to proceed with treatment. The Board has to consider the advance directive when making its decision.

Freedom from Torture and Cruel Treatment or Punishment

- Some people believe that it is cruel to not treat a person living with a mental illness who is in danger to themselves or others or whose physical or mental health has or will substantially deteriorate.
- There is a lack of timely access to treatment by people living with a mental illness who are incarcerated. Some believe that this is equivalent to a form of torture or cruel treatment.
- MHCC has issued a paper on seclusion and restraint practices which advocates for a reduction in their use.

Living Independently in the Community

- There is a lack of available affordable housing options for persons living with a mental illness.
- Inadequate social assistance rates and a lack of access to private disability insurance are barriers to living independently.

Access to Physical and Mental Health Treatment and Services

- There are challenges related to persons having access to primary health care professionals.
- In rural/northern areas, it is difficult for persons who have been apprehended by the RCMP to access hospital-based mental health services. The lengthy wait times in emergency rooms act as a deterrent for police officers to take a person to hospital as opposed to charging them with an offence.
- It was noted that persons living with a mental illness who are in Winnipeg's Remand Centre are not always taken to hospital when acute mental health care is required unless there is a psychiatric bed available, and often there is not.
- In rural/northern areas, access to mental health assessments is limited. Video-conferencing technology needs to be used more widely for this purpose.
- The health care system is slowly evolving to ensure that people are aware of all the treatment options. This is occurring in the field of cancer treatment and should be adopted by the mental health field.
- *The Mental Health Act* is about restricting people's rights and should be focused on what people need and should be getting.
- Even when policies exist that encourage choice of service or service provider, in reality there is often no choice. People who request different community mental health workers or psychiatrists are seen as 'causing trouble'.

d. Human Rights Environment

Expansion vs. Restriction of Human Rights

- There does not seem to be an unfavourable attitude towards human rights, however it is recommended that if there are proposals to change mental health practices then the resources necessary to implement the alternatives must be made available, such as funding and training.
- Manitoba's *Vulnerable Person's Act* reflects an intention to acknowledge more fully the rights of persons with disabilities.

Recent Events

- The murder of a young man on a Greyhound bus by an individual who was ultimately found to be Not Criminally Responsible generated a considerable amount of media attention in Manitoba. Some believe the media reports and the reaction by the public reinforced negative and harmful stereotypes that persons living with a mental illness are violent and dangerous.
- Another example of a recent event was the arrest of a man who has Alzheimer's disease and who assaulted his wife. The wife called the police and the man was arrested and taken to the Remand Centre where he languished for several weeks as there was no personal care home bed available and the wife could no longer live with her husband without adequate supports.

Current Initiatives

- The provincial government is interested in taking the lead on monitoring the implementation of the CRPD and is also promoting new accessibility legislation. In addition, the province announced its intention to establish an adult abuse registry for all populations including the protection of vulnerable adults.
- The province's recently released mental health strategy does not address human rights specifically but it does address the issues of increased access to services and decreasing stigma.
- Non-government community organizations such as Winnipeg Harvest and the North End Women's Resource Centre are taking the initiative to address mental health issues.
- The Canadian Human Rights Museum is currently being built and this may be an opportunity to highlight issues related to mental health and human rights.

3. *British Columbia*

a. Existing Mental Health Legislation, Policies and Standards

Legislation

- Similar to Nova Scotia and Manitoba, British Columbia has several pieces of legislation that impact persons living with a mental illness, including: the *Mental Health Act; Forensic Psychiatry Act; Health Care Consent Act; Adult Guardianship Act; Patient's Property Act; Representation Agreement Act,* and others.
- There is some overlap among the different pieces of legislation which may be contradictory.
- The Federal *Criminal Code* interfaces with BC's *Mental Health Act* with respect to involuntary treatment. In particular, the application of s. 672 of the *Criminal Code* is quite different in BC. For example, if someone is detained in custody and refuses treatment, there is an assumption that the person can be treated involuntarily, or against their will.
- Unlike Nova Scotia and Manitoba, involuntary admission and treatment are combined in BC's *Mental Health Act*, meaning that if someone is involuntarily admitted to a mental health facility, they can also be treated against their will.

Policy

- In the absence of legislation and policies, there are protocols that outline expectations. For example there are regional protocols directing the transition of youth from the child and adolescent mental health service system to the adult mental health service system.

Standards

- Each Regional Health Authority is required to become accredited through Accreditation Canada. This is considered to be the primary source for service standards.

b. Existing Monitoring Bodies/Organizations

- British Columbia has a number of organizations that accept individual complaints; however none are specific to mental health. These include the Police Complaint Commission; BC Ombudsperson; BC Human Rights Tribunal; and the BC Civil Liberties Association.
- The Child and Youth Representative was established over concerns regarding children in care and they monitor and investigate complaints.
- There is currently no organization in BC that consistently monitors legislation, policy and standards regarding the human rights of persons living with a mental illness. At one time, there was a provincial mental health advocate that provided a systemic overview based on the issues coming forward from mental health service users; however the funding for this position was withdrawn after two years.

Human Rights Coalition

- In the absence of a Human Rights Commission in BC, the BC Human Rights Coalition does engage in law reform. The Coalition includes a small legal clinic that represents individuals coming forward with complaints, 20% of which are complaints related to

mental health issues. It is a free service primarily funded by the Attorney General's Office and the Law Foundation. Eligibility for the service is not based on income but rather on the merits of the complaint.

Mental Health Review Board

- BC's Mental Health Review Board has a limited monitoring function whereby it reviews the circumstances of persons who have been detained in a mental health facility for over one year and have not made an application to the Board.
- It is a requirement of the Review Board that one member be a medical practitioner but it is not mandatory that this person be a psychiatrist. In addition, it may be difficult to find a sufficient number of medical practitioners who are available to sit on the Review Board at the time of hearings due to time constraints.
- The role of the Review Board staff is to accept appeals and set hearing dates and is not to provide legal advice or represent the person at the hearing. Persons appealing to the Review Board frequently require an advocate to accompany them, but this often does not occur.
- The Review Board does not hear appeals regarding statutory property guardianship certificates. This means that if a person is found by reason of mental disorder not to be competent, the person cannot appeal the finding.

Patient Advisor

- Only two hospitals in BC have a Patient Advisor under contract; namely Riverview and the Forensic hospital. Like Nova Scotia, the Patient Advisor informs individuals about their rights and is not an advocacy service. Beyond these two hospitals, it is up to the clinical staff to provide information to individuals about their rights.

Provincial Quality Review Board

- The Provincial Patient Quality Review Board is for all patients of health facilities and is an alternative route if the other avenues of complaint are not satisfactory. The Board's mandate includes all health facilities, community health services, and services provided by health authorities.

c. Realization of Human Rights

Access to Justice

- It is unfair to expect people to represent themselves before the Review Board. Legislative reform is needed to ensure that all persons appearing before the Review Board are represented.

Liberty and Security of the Person

- There exists a moral dilemma when a person has a right to refuse treatment and has no insight into their illness. Should they be left untreated and possibly put themselves and others at risk or should they be forcibly treated?

- In BC there is an important distinction in that involuntary hospitalization and involuntary treatment are one in the same, unlike Ontario where a person can be involuntarily hospitalized and not treated.
- BC has health care consent legislation and representation agreement legislation that address the issue of appointing someone to make decisions on a person's behalf, however these two pieces of legislation do not apply to persons who have been involuntarily committed to a mental health facility.
- Ulysses Agreements are like planning documents that assist persons to state their preferences for treatment and support. Unlike representation agreements, they are not legally binding.
- There has been no evaluation of people on extended leave from hospital (involuntary status) and the impact on their quality of life. People's rights are restricted but it is not known how the extended leave improves or does not improve their mental health.

Freedom from Torture and Cruel Treatment or Punishment

- Mental health treatment has become more humane over the past several decades, with side effects from medication being much fewer.
- There are known instances when persons in a mental health facility have been placed in seclusion for refusing treatment.
- The use of restraint and seclusion practices is considered by some to be effective. For example, persons can be placed in seclusion until their antipsychotic medication takes effect.

Living Independently in the Community

- There is a lack of housing for persons living with a mental illness and addiction, and as a result there is a problem with homelessness. This is especially relevant to people being discharged to the community from Riverview Hospital.
- People living with a mental illness should have the opportunity to choose from a range of housing options.

Access to Physical and Mental Health Treatment and Services

- There is a need for mental health assessments that are free from bias and do not label people unnecessarily. The population is diverse and needs are expressed differently.
- There exists a significant disparity in the availability of hospital and community-based mental health services for children and youth across the regions. A child and youth mental health plan was released by the province several years ago and this did result in short-term enhancements to child and adolescent mental health services, but it was not maintained in the long-term.

d. Human Rights Environment

Expansion vs. Restriction of Human Rights

- There has been a positive change in attitude toward people with addictions and recognition that they have an illness. Mental illness and addictions have been addressed simultaneously which further reduces the stigma.

Recent Events

- Paul Boyd, a man with bi-polar illness, was shot by police and this has had an impact on how persons living with a mental illness are perceived.
- As a result of the Olympics, homelessness and housing issues have been highlighted.

Current Initiatives

- In response to the closure of Riverview Hospital, an initiative is underway to build community capacity including the provision of education to the public and the police as well as establishing a tertiary transition fund for the community to draw on as a way of developing needed services.
- While beds are closing at Riverview Hospital, beds are opening in other regions.
- The provincial government has been actively reducing budgets in all government departments.
- As a result of a murder/suicide in one of Victoria's municipalities, the police established a domestic unit that specializes in mental health.
- The City of Victoria has implemented a "streets to home model" to address the issue of homelessness.
- Assertive Community Treatment (ACT) Teams have been established to work with persons who have multiple issues including mental illness, addictions, and homelessness.
- The MHCC project on homelessness is being piloted in Vancouver with a focus on people living with a mental illness and addictions.
- There is a Community Action Initiative supported by mental health, First Nations, Aboriginal and Métis associations and government to establish resources for persons living with a mental illness who are also experiencing problematic substance use issues.
- There has been a profound change in how the concept of recovery has impacted policy development. Peer support is now accepted as the norm in mental health services.
- BC's recently released a 10-year mental health plan that has a governance model and accountability built in, including an evaluation of the mental health system. Also included is the goal to reduce stigma regarding mental illness and addictions.

E. Pilot Site Implementation of Mental Health and Human Rights Evaluation Instrument

1. Process

Following an invitation to all prospective stakeholders, three organizations were chosen to lead the pilot implementation of the draft Evaluation Instrument in each of their respective jurisdictions, namely:

Nova Scotia -	Preventing Criminalization of People with Mental Illness, led by Dr. Jean Hughes, Dalhousie University
Manitoba -	Manitoba Human Rights Commission, led by Dianna Scarth, Executive Director
British Columbia -	BC Schizophrenia Society, Victoria Branch, led by Hazel Meredith, Executive Director

A description of the roles and responsibilities for the lead organizations (i.e. Pilot Evaluation Teams) can be found in the Terms of Reference located in Appendix D. The lead organizations were asked to apply the Evaluation Instrument to their respective Mental Health Acts and the most current mental health provincial policies and service standards, and complete the process over a three month period. The lead organizations were asked to invite a group of stakeholders to participate in the evaluation exercise that would ideally include individuals representing: the legal sector; human rights organizations; mental health service sector, e.g. psychiatrist, mental health workers; government policy-makers; mental health non-government organizations; family members; and, persons with lived experience. All three lead organizations extended invitations to a broad range of individuals representing each sector as listed above.

Three separate training sessions were held via video conference (Nova Scotia and British Columbia) and in-person (Manitoba) with the individuals involved in leading the pilot in each jurisdiction. The bulk of each training session consisted of instruction in the use of the Evaluation Instrument and the method to gather the responses from the group of participating stakeholders. There was flexibility in the method chosen by each jurisdiction to gather the responses in order to accommodate for the nuances in each jurisdiction; however each jurisdiction was required to meet the following minimum expectations:

- An initial meeting is held to review the Terms of Reference and establish the group's process for completing the Evaluation Instrument including the timeframe for completion of the task.
- The group's process could consist of pre-scheduled group meetings with individuals asked to complete the Evaluation Instrument in between meetings, or the group could decide to complete it together.
- Regardless of the method chosen, the group should come together in order to discuss the responses and, as much as possible, reach a consensus on the responses provided. Where there is significant debate, this should be noted and included in the feedback given to the Project Team on the Evaluation Instrument.

Each pilot jurisdiction adopted a slightly different process in applying the Evaluation Instrument to their respective mental health legislation, policies, and standards, a summary of which is as follows:

Nova Scotia

- Nova Scotia applied the instrument to the *Involuntary Psychiatric Treatment Act (IPTA)* and the Provincial *Standards for Mental Health Services (2009)*. At the time of this Project, Nova Scotia did not have mental health policies at the provincial level.
- The representatives that accepted an invitation to participate in the evaluation exercise included: a Legal Aid lawyer; two lawyers from the academic sector as well as Board members of CMHA, Nova Scotia; a forensic psychiatrist; a social worker from Canada Corrections; an individual representing a mental health supported employment organization; a Nurse; an Occupational Therapist; and a member of the Consultation Group.
- The process to complete the instrument involved the lead organization scheduling two separate meetings (totalling of one and half days) with their group of participants. Both meetings were facilitated discussions. On the first day, the facilitator reviewed the Evaluation Instrument, the process to complete it, and went through sample questions to demonstrate how the process would unfold. The remainder of the first day and the entire second half day was devoted to discussion of each question in the Evaluation Instrument and drafting a response. A consensus was achieved on the scoring of the evaluation questions, e.g. addressed in full, partially addressed, and not at all addressed, however not all questions were answered.

Manitoba

- Manitoba applied the Evaluation Instrument to *The Mental Health Act*, as well as the following policies:
  - *Order of Committeeship Issued by the Director of Psychiatric Services (January 2008)*
  - *Family Member and Natural Support Participation in Mental Health Service Planning, Implementation and Evaluation (May 2005)*
  - *Consumer Participation in Mental Health Services Planning, Implementation and Evaluation (October 2003)*
- The representatives that accepted an invitation to participate in the evaluation exercise included: a Youth Program Facilitator, Manitoba Justice; family member; mental health non-government organization; Office of Manitoba Ombudsperson; Policy Analyst, Manitoba Health; Child and Family Services, Northern Manitoba; Public Trustee's Office; a member of the Consultation Group and a Hospital-based mental health program.
- The process to complete the Evaluation Instrument involved the lead organization inviting all participants to a half-day meeting to receive instruction on the Evaluation

Instrument and the process to complete it. At the conclusion of the training session, participants were asked to choose one of six sets of questions to complete. Two participants were assigned to complete one of the six sets of questions. Due to time constraints, there was no follow-up meeting of the group scheduled, and as a result, there was no group discussion on the responses and therefore no consensus reached for each response.

British Columbia

- British Columbia applied the Evaluation Instrument to the *Mental Health Act*, the provincial mental health and substance use plan *Healthy Minds, Healthy People – A 10-year Plan to Address Mental Health and Substance Use in British Columbia (November 2010)*, and *Standards and Guidelines for Early Psychosis Intervention Programs (September 2010)*.
- The representatives that accepted an invitation to participate in the exercise included: two family members; two mental health non-government organizations; two persons with lived experience, one of whom was a member of the Consultation Group; a lawyer; and two individuals from the BC Ministry of Health.
- The process to complete the Evaluation Instrument involved the lead organization hosting a full day meeting of the participants and a separate videoconference. Both meetings were facilitated discussions. During the first meeting, instruction was provided to the group on the Evaluation Instrument and the process used to complete it. As a group, the Evaluation Instrument was applied to the *Healthy Minds, Health People* Plan. During the second meeting, and again as a group, it was used to evaluate the *Mental Health Act* and the *Standards and Guidelines for Early Psychosis Intervention Programs*.

2. Participant Questionnaires

Questionnaires were distributed to all of the participants in Nova Scotia and Manitoba following the completion of the evaluation exercise. In the case of BC, there were different participants in each of the two sessions held, so the questionnaires were distributed at the conclusion of each session. The questionnaires consisted of questions scored on a Likert scale to assess the participant's perception of specific aspects of the Evaluation Instrument, the evaluation process, and the knowledge gained with respect to mental health and human rights as a result of their participation. The questionnaire is located in Appendix E.

Overall, the responses to the questionnaire indicate that, for the most part, the Evaluation Instrument is effective in analyzing mental health legislation, policy and standards against key principle and human rights; however, there are aspects of the Evaluation Instrument and evaluation process that require adjustment. Also, a majority of the participants that completed the questionnaire indicated that participation in the evaluation process resulted in increased knowledge of mental health and human rights as well as an understanding of what principles

and human rights are sufficiently addressed through existing legislation, policies and standards and what areas require improvement.

3. Summary of Evaluation Results

For a summary of the evaluation results by province, refer to Appendix F.

VII. IMPLICATIONS

This section on *Implications* draws from all of the information gathered and serves to highlight the key findings and their subsequent impact on: the Evaluation Instrument; legislative reform; policy development; and standards development.

A. Mental Health and Human Rights Evaluation Instrument

Process

- In some cases, participants were not provided with the legislation, policy or standard being reviewed and they were difficult to find on-line. The documents reviewed need to be provided to all participants.
- The amount of reading required in preparation for completing the Evaluation Instrument was considered by some to be excessive, i.e. reviewing the legislation, policies and standards to be evaluated. This may be less of an issue for people who are already familiar and working with these documents.
- The written instructions included in the Evaluation Instrument are brief and for some, not clear. This indicates that perhaps the instructions should be revised and incorporated into the training session at length.
- The timeline to complete the Evaluation Instrument was very short. There is a consensus across all three jurisdictions that more time is needed to complete the Evaluation Instrument in order to conduct an effective evaluation.
- The Evaluation Instrument is considered by some to be too lengthy. Reducing its length could be accomplished by eliminating any duplication.

Responses

- Often times the discussions among the evaluation participants addressed how the existing legislation, policies and standards were not reflected in practice. In other words, even though legislation, policies and standards existed they did not guarantee that an individual's human rights were respected in practice. This indicates that not only is it important to examine what legislation, policies and standards exist, but the extent to which they are or are not incorporated into practice. This will require that the Evaluation Instrument be revised to capture practice issues.

- Some participants found the Evaluation Instrument to be confusing. For example, evaluation questions were answered with reference to legislation when the section referred to policy. This may require that the format of the Evaluation Instrument be altered so that the legislation, policy and standards sections are made clearer. It could also mean that the Evaluation Instrument should be tailored for each jurisdiction. For example, if there are no provincial mental health policies, then these sections would be deleted. Also, the name of the specific legislation, policy or standard being evaluated could be placed at the beginning of each section.
- Across all three jurisdictions, there was not a great deal of detailed analysis conducted in response to each question in the Evaluation Instrument. In some cases, the relevant sections from the legislation, policy or service standard was not referenced, and in some cases the responses were very broad. This can be attributed to the short amount of time given to complete the Evaluation Instrument. It can also be as a result of inadequate training on the Evaluation Instrument and an absence of facilitated discussion.
- There were errors noted in the participant responses, especially as it relates to the analysis of legislation. Analysis of legislation is a specific skill and it is important that an individual(s) with this skill set is included in the group of evaluation participants.
- The categories for the responses, i.e. elements addressed in legislation, elements missing, did not enable some participants to provide a thorough response to the question. This could be due to the reason that responses are not as clearly divided as these categories. This could perhaps be resolved by adding a section on mental health practice that would permit participants to provide more explanatory information.
- Similarly, the scoring scale of 'fully addressed', 'partially addressed', and 'not at all addressed' were not adequate for some participants. For example, a part of legislation may fully address one area but only partially address another area within the same principle or right. This will require that the definition for each score category is more clear and captures a greater range of possible responses.
- For some principles and rights in the Evaluation Instrument there were evaluation questions pertaining to legislation, policies and standards, while for others there were evaluation questions only for legislation or policies. This was a deliberate choice on the part of the Project Research Team because it was felt that some principles or rights would only be addressed in legislation or policies and not in legislation, policies and standards. In some cases, the evaluation groups indicated that there should be evaluation questions pertaining to all three areas. This should be re-examined with a view to determining whether additional evaluation questions should be added.

Recording Data

- The recording of the participant responses is cumbersome as the summary of the scoring for each question is inserted in separate tables at the end of the Evaluation Instrument, and the recording of the discussion is inserted in the Evaluation Instrument

itself. Also, the electronic version of the Evaluation Instrument that was provided to the pilot jurisdictions for the purpose of recording the groups' findings did not provide sufficient space to enter the responses. It is evident that there is a need to provide an easier and more user-friendly means to record the responses of the evaluation groups, such as an electronic format that provides sufficient space for responses.

B. Legislative Reform

- There are several pieces of legislation in any one jurisdiction that have an impact on persons living with a mental illness. The CRPD builds on the social model of disability by including human rights that promote the removal of barriers in the environment so persons living with a disability can be included in society. As a result, different legislation will address barriers; and an evaluation of all relevant legislation becomes necessary.
- When Canada ratified the CRPD it entered a reservation regarding Articles 12(2) and (3) to protect its ability to continue the use of substitute decision-making arrangements in appropriate circumstances and subject to appropriate and effective safeguards. However, this does not prevent the provinces from restricting the use of substitute decision-making nor does it prevent the provinces from including supported decision-making options in legislation. It is also worth noting that Canada can remove its reservations at any time.
- Article 15 of the CRPD refers to freedom from torture or cruel, inhuman or degrading treatment or punishment. The Article is brief and allows for a great deal of interpretation regarding the definition of 'torture' and 'cruel, inhuman or degrading treatment or punishment'. It is important that if this Article is monitored in relation to persons living with a mental illness, its definition is developed with and by persons living with a mental illness and includes aspects that are seen as torture or cruel, inhuman or degrading treatment or punishment as defined by them.
- Articles 12 and 14 (right to equal recognition before the law, and right to liberty and security of person) are the most contentious and debated rights in the CRPD largely due to the reason that they have an impact on involuntary hospitalized and treated. These rights polarize the debate between a person being hospitalized and treated against their will for the protection of themselves and society, and a person's right to refuse admission and/or treatment. Some believe that people who are acutely mentally ill are not aware they are ill and therefore involuntary admission and treatment are justified. Others believe that individual human rights should prevail and involuntary hospitalization and treatment is rarely, if ever justified. Existing mental health legislation typically attempts to strike a balance between protecting society and respecting an individual's human rights. Involuntary admission criteria have been expanded to also include admission for the purposes of treatment if the person's physical or mental health would otherwise significantly deteriorate, resulting in additional means by which individuals can be involuntarily admitted and treated.

- Article 3 of the CRPD lists 'accessibility' as one of its general principles. The term as it relates to persons living with a mental illness has not been clearly articulated in the CRPD or elsewhere. Most often it is described in relation to persons with physical or intellectual disabilities, such as accessible doorways to buildings for wheelchair users and communication devices for persons unable to speak. Similar to Article 15, it is important that 'accessibility' as it relates to persons living with a mental illness is articulated. 'Access' to services can go beyond simply being accepted into a program. Access can also be affected by a lack of culturally relevant programs, a person's finances and also the degree to which a program stigmatizes persons living with mental illness, such as public housing programs.
- The mental health legislation in the three pilot jurisdictions states that an individual has a right to a lawyer or advocate; however how this right is realized is a challenge.
- Canada's *Criminal Code* and how it interfaces with provincial/territorial mental health legislation was beyond the scope of this Project; however it is an issue that often surfaced throughout the course of this Project and is an issue that requires specific attention.

C. Policy Development

- There are mental health policies developed by facilities/organizations, region or district health authorities, and the provincial/territorial governments.
- Mental health policies developed at the facility/organization level are usually specific to directing staff conduct.
- Although some regions/districts attempt to ensure that their mental health policies are in-line with provincial/territorial policies, this is not a consistent practice.
- Mental health policies developed by provincial/territorial governments are usually developed in reaction to a specific event or issue that has come to the government's attention.
- Provincial mental health strategies or action plans that have been or are being developed do not systematically address the principles and human rights included in the CRPD. Rather, the policies developed most often focus on the process by which mental health organizations provide services.
- The accountability measures included in facility/organization, region/district, and provincial policies are minimal or absent.
- Policies as well as standards are largely unknown to the individuals living with a mental illness or the public at large.
- There is no body or mechanism in place beyond complaints-driven entities such as the Ombudsperson and the Human Rights Commissions that consistently and proactively monitors if mental health policies are being adhered to in facilities/organizations, regions/districts or at the provincial/territorial level.

D. Standards Development

- There are few mental health standards in existence in provinces/territories, and in the absence of a monitoring mechanism, the accountability rests on self-assessments.
- Provinces/territories largely rely on Accreditation Canada for the provision of mental health standards to set the bar for the minimal standards that mental health services need to meet. The provincial/territorial governments are notified that a service has been accredited, but the extent to which standards are met is not shared outside the organization or Accreditation Canada.

VIII. RECOMMENDATIONS

The recommendations listed below stem from the implications of the research findings and address the Evaluation Instrument; provincial/territorial evaluation of mental health and human rights; legislative reform; mental health policy development; mental health standards development; and, national human rights monitoring in the mental health sector.

It is important to note that the recommendations are to be interpreted with the understanding that all activities associated with the evaluation of mental health legislation, policies and standards, as well as the monitoring and reporting functions are conducted with the involvement and participation of persons living with a mental illness including women and Aboriginal people.

A. Mental Health and Human Rights Evaluation Instrument

Training

- Training on the Evaluation Instrument should be provided to all participants in the evaluation process including the facilitator(s).
- Training on the Evaluation Instrument should be provided at a minimum for one full day to allow for sufficient practice in its use.
- Training should include an orientation to the evaluation process; instruction on the legislation, policies and standards to be evaluated; and the key rights as they pertain to persons living with a mental illness.
- Training should include instruction on completing responses in the Evaluation Instrument such as including references to specific sections of legislation, policies and standards; the analytical process to determine the response to an evaluation question; and how to fully complete a response to an evaluation question.
- Training should include practice examples taken from actual legislation, policy and standards so that participants can become better versed in the Evaluation Instrument.

Process to Evaluate Legislation, Policies and Standards

- All participants should receive or have access to all material related to the evaluation including the legislation, policies and standards being evaluated at a minimum one week before the evaluation process begins to allow ample time for participants to read and become familiar with the documents being evaluated.
- The time to complete the Evaluation Instrument should be increased from three months to a minimum of six months to allow for a thorough and complete evaluation of legislation, policy or standard, and the timeframe should be flexible to accommodate the participants' schedules.
- The Evaluation Instrument should be completed using a facilitated small group discussion format in which there are separate individuals fulfilling the facilitation and recording functions.
- The participants in the evaluation exercise should include a range of individuals that can provide information about similarities and differences between a law, policy, or standard and the experiences in practice. The participants should include at a minimum sector representatives from law (lawyers, judges), government (policy-makers), non-government (advocates), health facilities/organizations (service providers including psychiatrists and community mental health workers), as well as persons living with a mental illness, and family members. In addition, individuals with an ability to analyze legislation, policies and standards should be included in the group of evaluation participants.

Changes to the Evaluation Instrument

- The Evaluation Instrument should include references to terms defined in the glossary throughout the document.
- The instructions on how to complete the Evaluation Instrument should be revised to be more comprehensive and clear.
- The length of the Evaluation Instrument should be shortened by eliminating duplication in the evaluation questions; however, it is also necessary that evaluation questions be added based on specific feedback from the evaluation participants.
- The scoring scale for the evaluation questions, namely 'Addressed in Full', 'Partially Addressed', and 'Not at all Addressed', should be more clearly defined in the instructions for the Evaluation Instrument.
- The response sections of the Evaluation Instrument should be adjusted to capture information related to the realization of the legislation, policy or standard in practice.
- The response sections of the Evaluation Instrument should be revised to include an area where evaluators can provide their recommendations following the identification of what in the legislation/policy/standard has been addressed and what is missing in relation to a particular right.

- The formatting of the Evaluation Instrument should be changed so that the sections on legislation, policy and standards are sufficiently clear to the evaluator.
- The Evaluation Instrument should be tailored to the provincial/territorial context. For example, if there are no provincial/territorial policies, then these sections should be deleted from the Evaluation Instrument and a notation inserted that a deletion was made and the reason for the deletion. Also, the names of the specific legislation, policy or standard being evaluated should be inserted into the Instrument.

Completing and Submitting Responses

- An electronic version of the Evaluation Instrument should be developed that provides ample space for responses.

B. Provincial/Territorial Evaluation of Mental Health and Human Rights

- As Canada is a Federation and many of the rights contained in the CRPD either fall under the responsibility of the provincial/territorial governments or there is overlapping responsibility between the federal and provincial/territorial governments, it is recommended that each province and territory undertake an evaluation of their mental health legislation, policies and standards.
- Mental health legislation, policy and standards should be evaluated against the CRPD using the Evaluation Instrument so the human rights of persons living with a mental illness are respected and are not over-looked.
- A plan should be developed by each province/territory based on the evaluation results to reform legislation, and develop policies and standards.

C. Legislative Reform

- Within each province/territory, there are several laws in addition to mental health legislation that impact persons with living with a mental illness. It is recognized that it may not be feasible for all of the principles and rights contained in the CRPD to be addressed in a single Mental Health Act, and as such, other legislation will need to be assessed to ensure they are all addressed.
- Provincial/territorial mental health legislation could be amended to include the obligations of government to protect and advance the rights of persons living with a mental illness as outlined in the CRPD, in particular:
    - Limiting the use of substitute decision-making by indicating it is a method of last resort and promoting supported decision-making as the preferred method of decision-making (Article 12).
    - Providing a definition of torture and cruel and degrading treatment that includes a reference to the misuse of seclusion and restraint practices, and stipulating that measures should be taken to reduce such practices (Article 15).

- Providing a definition of accessibility as it pertains to persons living with a mental illness that includes attitudinal barriers to access such as stigma and prejudice, and the government's obligation to address access issues (Article 3).
- Maintaining a balance between an individual's human rights and the protection of society by emphasizing that involuntary committal and treatment are a last resort when all other options have been attempted (Article 14).
- Requiring that an individual not only has the right to counsel or an agent when appearing before the Mental Health Review Board, but also additional measures be taken to realize this right in a meaningful way. For example, the legislation could require the Review Board appoint a representative to appear at the hearing and act on the person's behalf if the person is unable to attend the hearing and has not appointed someone else to act on his/her behalf (Article 13).

- Provincial/territorial mental health legislation could be amended to incorporate the promotion of positive rights, as outlined in the CRPD, namely: the right to live independently and be included in the community, including the right choose housing and the right to a range of in-home and community supports (Article 19); the right to employment and employment supports (Article 27); the right to education and education supports (Article 24); and, the right to an adequate standard of living and social protection (Article 28).
- The *Criminal Code* and the interface with provincial/territorial mental health legislation raises specific issues related to human rights violations that require specific attention, research, and recommendations.

D. Policy Development

- Provincial/territorial policies should be developed to address the human rights of persons living with a mental illness and they should be applicable to all mental health facilities, and organizations, as well as regional and district health authorities. The policies developed should derive their authority from mental health legislation and also contain enough detail to set the direction of how mental health services are delivered with the protection of human rights in mind. For example, there could be a provincial/territorial policy that directs minimizing the use of restraint and seclusion practices with a goal of eliminating these practices.
- Mental health policies developed at the facility/organization and region/district levels should mirror or be an extension of, and not conflict with provincial/territorial mental health policies. Mental health policies developed at all levels should be coordinated to avoid a patchwork of conflicting policies across a province/territory.

- Provincial/territorial mental health policies should include a description of the mechanism to monitor the implementation of the policy to determine if it is being effectively implemented within the facility, organization, region or district.

E. Standards Development

- Provincial/territorial standards for mental health services should be developed that echo the principles and rights found in the CRPD and should derive their authority from legislation and policies.
- If a province/territory develops mental health service standards, then it is crucial that an external, independent body be mandated with the responsibility to monitor a facility's or an organization's ability to meet those standards. Voluntary self-assessment is not sufficient.
- If a province/territory chooses to rely on the Accreditation Canada process to evaluate mental health services according to a set of standards, then the standards should be adjusted to reflect the principles and rights in the CRPD and the organization being evaluated should be required to report its evaluation results to funders, e.g. government, and a monitoring body.

F. National Human Rights Monitoring in the Mental Health Sector

- A nation-wide dialogue on mental health and human rights should be initiated and facilitated and include the links between the key principles and rights in the CRPD and the current status and potential impact on persons living with mental illness.
- In the absence of a national plan to implement and monitor the principles and rights contained in the CRPD, it is recommended that such a plan be developed, and ideally, be developed by a coalition of national non-government disability organizations and human rights organizations, including a national mental health organization whose principles and values mirror those in the CRPD.
- If a national independent mechanism is established to monitor the implementation of the CRPD, then the mental health community including non-government mental health organizations such as the MHCC should work collaboratively with this entity as well as the broader disability community to ensure that issues specifically relevant to persons living with a mental illness are known and incorporated into the monitoring plan.

IX. STRATEGIC PLAN

The Strategic Plan centers on the evaluation of mental health and human rights and the national process to monitor the implementation of the principles and rights contained in the CRPD as it relates to persons living with a mental illness. These two processes are

interdependent, and in order to be effective and do justice to the CRPD, they should occur simultaneously.

This Project focused primarily on the development of the Evaluation Instrument to measure the degree to which human rights are incorporated into existing mental health legislation, policies and standards and to identify the areas in legislation that require reform and the policies and standards that need to be developed to protect and advance the rights of persons living with a mental illness. It is important at this stage, and through the Strategic Plan to identify the actions required so that the Evaluation Instrument is effectively used by all of provinces and territories.

Canada is required to report to the UN Committee on the CRPD of its progress in implementing the principles and rights contained in the CRPD. The first report is due to be submitted by March 2012. The federal government has not set out national plan to implement the CRPD nor has it designated an independent monitoring mechanism to track and report on the progress made in implementing the CRPD. As such, it is very timely that the Strategic Plan outlines the proposed actions to monitor and report on the implementation of the CRPD as it relates to persons living with a mental illness.

The tables below contain the Project Research Team's proposed Strategic Plan in two sections: one section addresses the evaluation of mental health and human rights and the other section refers to the national monitoring and reporting process. Both sections outline the recommendations stemming from the research, the actions to address the recommendations, the responsible parties to carry out the actions, and the proposed timeframe for the completion of the actions.

Evaluation and Implementation of Mental Health and Human Rights

A. MENTAL HEALTH AND HUMAN RIGHTS EVALUATION INSTRUMENT			
RECOMMENDATION	**ACTIONS**	**RESPONSIBLE**	**TIME FRAME**
Revise Evaluation Instrument based on recommended changes	1. Incorporate the recommended changes into a revised version of the Evaluation Instrument.	Project Research Team	Completed
	2. Incorporate the recommended process to complete the evaluation into a revised version of the Evaluation Instrument.	Project Research Team	Completed
Provide training on the Evaluation Instrument	1. Release to the public the Project's Final Report, Evaluation Instrument and Photovoice	MHCC	December 2011

A. MENTAL HEALTH AND HUMAN RIGHTS EVALUATION INSTRUMENT			
RECOMMENDATION	**ACTIONS**	**RESPONSIBLE**	**TIME FRAME**
	presentation.		
	2. Provide training in the use of the Evaluation Instrument.	MHCC or other non-government mental health organization.	January – March 2012

B. PROVINCIAL/TERRITORIAL EVALUATION OF MENTAL HEALTH AND HUMAN RIGHTS			
RECOMMENDATION	**ACTIONS**	**RESPONSIBLE**	**TIME FRAME**
Each province and territory undertakes an evaluation of their mental health legislation, policies and standards.	1. Each province and territory evaluates their laws, policies and standards against the principles and rights contained in the CRPD.	Provinces and territories	March – December 2012
Provincial/territorial laws, policies and standards are evaluated against the CRPD using the Evaluation Instrument.	1. Each province and territory uses the Evaluation Instrument to assess current laws, policies and standards.	Provinces and territories	March – December 2012
Each province and territory develops an action plan based on the evaluation results.	1. Each province and territory develops an action plan to reform legislation, and develop policies and standards based on the evaluation results.	Provinces and territories	January – June 2013

C. LEGISLATIVE REFORM			
RECOMMENDATION	**ACTIONS**	**RESPONSIBLE**	**TIME FRAME**
Legislation in addition to mental health legislation should be assessed for inclusion of human rights.	1. Provinces and territories should assess all laws that may impact persons living with a mental illness for inclusion of human rights	Provinces and territories	March – December 2012
Provincial/territorial mental health legislation could be amended to include obligations of government to protect and advance the rights of persons living with a mental illness.	1. Provincial/territorial laws are amended based upon the evaluation results and noting in particular the recommended changes outlined in Section C of the Recommendations.	Provinces and territories	July 2013 onward
Provincial/territorial mental health legislation could be amended to	1. Provincial/territorial laws are amended to include the positive	Provinces and territories	July 2013 onward

C. LEGISLATIVE REFORM			
RECOMMENDATION	**ACTIONS**	**RESPONSIBLE**	**TIME FRAME**
incorporate positive rights as outlined in the CRPD.	rights contained in the CRPD.		
The *Criminal Code* and the interface with provincial/territorial mental health legislation raises specific issues related to human rights violations that require specific attention, research, and recommendations.	1. A research project is initiated that focuses on the interface between provincial/ territorial mental health legislation and the *Criminal Code* as it relates to human rights.	To be determined	

D. POLICY DEVELOPMENT			
RECOMMENDATION	**ACTIONS**	**RESPONSIBLE**	**TIME FRAME**
Provincial/territorial mental health policies should be developed to address the human rights of persons living with a mental illness and should derive their authority from mental health legislation.	1. Provinces/territories develop mental health policies based on the evaluation results and stem from legislation with sufficient detail provided to direct mental health service delivery.	Provinces and territories	July 2013 onward
Mental health policies at facility, regional, and provincial levels should be coordinated for consistency.	1. Provinces/territories establish a coordination mechanism so that the mental health policies developed at all levels are consistent.	Provinces and territories	July 2013 onward
Provincial/territorial policies should include a description of the mechanism to monitor the implementation of the policy at facility, organization, region and district levels.	1. Provinces/territories establish a mechanism to monitor the implementation of mental health policies.	Provinces and territories	July 2013 onward

E. STANDARDS DEVELOPMENT			
RECOMMENDATION	**ACTIONS**	**RESPONSIBLE**	**TIME FRAME**
Provincial/territorial mental health standards should be developed that reflect human rights principles and are	1. Provinces and territories develop mental health standards that are based on the	Provinces and territories	July 2013 onward

E. STANDARDS DEVELOPMENT			
RECOMMENDATION	**ACTIONS**	**RESPONSIBLE**	**TIME FRAME**
consistent with mental health legislation and provincial/territorial policies.	evaluation results and are consistent with mental health legislation and policies.		
An external, independent body should be mandated with the responsibility of monitoring a facility's or organization's ability to meet mental health standards.	1. Provinces and territories mandate an external, independent body to monitor mental health standards.	Provinces and territories	July 2013 onward
If a province/territory chooses to rely on Accreditation Canada to set standards, then the standards should be adjusted to reflect human rights and the results reported to government and a monitoring body.	1. Provinces and territories choosing to rely on Accreditation Canada standards should ensure that the standards reflect human rights principles and the results are reported to government and an external monitoring body.	Provinces and territories	July 2013 onward

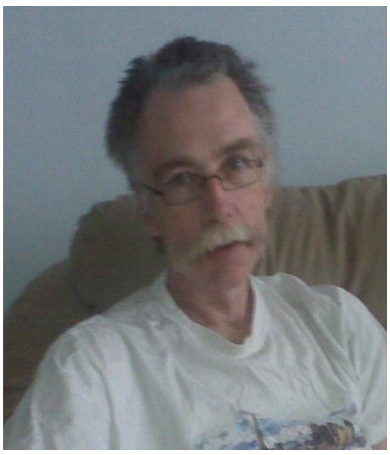
F. NATIONAL HUMAN RIGHTS MONITORING IN THE MENTAL HEALTH SECTOR			
RECOMMENDATION	**ACTIONS**	**RESPONSIBLE**	**TIME FRAME**
A nation-wide dialogue on mental health and human rights should be initiated and facilitated and include the links between the key principles and rights in the CRPD and the current status and potential impact on persons living with mental illness.	1. The MHCC acts as a catalyst in raising awareness and facilitating a dialogue among governments, non-government organizations, and the public on mental health and human rights as they relate to the CRPD.	MHCC	December 2011 onwards
A national plan to monitor the CRPD be established by a coalition of national non-government disability organizations including mental health organizations whose principles mirror those in the CRPD and human rights organizations.	1. The MHCC along with other national mental health organizations promotes and supports the development of a coalition of disability organizations including mental health organizations and	MHCC and other national mental health organizations	December 2011 onwards

F. NATIONAL HUMAN RIGHTS MONITORING IN THE MENTAL HEALTH SECTOR			
RECOMMENDATION	**ACTIONS**	**RESPONSIBLE**	**TIME FRAME**
	human rights organizations to form a coalition for the purpose of monitoring of the CRPD.		
	2. The coalition creates a shadow report for submission to the UN on the progress of implementing the CRPD and uses the results of the provincial/territorial mental health and human rights evaluation to form part of its basis.	Coalition of Disability Organizations	December 2011 – December 2012
If a national independent mechanism is established to monitor the implementation of the CRPD, then the mental health community including non-government mental health organizations such as MHCC should work collaboratively with this entity to ensure that issues specifically relevant to persons living with a mental illness are known.	1. The MHCC encourages mental health organizations to take an active role in representing the interests of persons living with a mental illness in the national monitoring process.	MHCC	November 2011 – ongoing
	2. The independent monitoring mechanism involves persons living with a mental illness in its processes, similar to the Consultation Group model used in this Project.	Independent Monitoring Mechanism (to be established)	Once an independent monitoring mechanism is established.

APPENDIX A: Consultation Group Member Biographies

Manitoba

Robert Kirkwood, Thompson, Manitoba



I have been a Mental Health client more than half of my life. I got into recovery in 1986, two years prior to that I was given no hope of recovery.
I live in a mining town in Northern Manitoba. My family made this our home. I've raised my own family here. Nine years of that was as a single parent.
I obtained a pardon September 8, 2008. I have had involvements with the Law for a variety of reasons. I have quite a bit of experience in both Criminal and Family Court.
The last number of years I've enjoyed quite a good life. For the past 11 years I've served on the board of our local CMHA. I served a two year term on the Manitoba Division Board. Last Fall I was recognized with a Heroes of Mental Health award. I currently work in the field of Mental Health.
I'm proud to be a Canadian. I feel honoured that I was asked to be part of this process.

Gail Sweetland, Winnipeg, Manitoba

Gail, a life-long Winnipegger, graduated with a Bachelor of Arts degree in 1978. Before getting involved in the mental health and addictions fields, Gail had a career in systems analysis and project management. She commenced her addiction recovery in 1975 and her mental health recovery soon after that.
Currently, Gail volunteers for CMHA and other mental health and addiction organizations at the local, regional and provincial levels. Her interests around mental health include housing, co-occurring disorders, stigma, justice and human rights.
Gail is grateful to have been selected for and looks forward to participating in this project.
Winnipeg, Manitoba

Nova Scotia

Keith Anderson, Sydney, Nova Scotia

Born on November 10, 1960, in Sydney, Nova Scotia. He graduated from Dalhousie Law School in 1983 and practiced law for three years. He then attended University College London, England, and obtained his Master in Laws in 1987. Keith returned to practice until 2003 at which time he was diagnosed with depression. He lost his health and career in the span of 5 days.

Keith has recovered and in the last two years he has become a mental health advocate. He has spoken at two national conferences and presented a speech in his hometown at the 5th Annual Living With Mental Illness Conference before an audience of 550 people. Keith has had articles appear in the National Post and in publications of the Canadian Bar Association, the American Bar Association, and the Nova Scotia Barristers' Society.

Wanda Cummings, Halifax, Nova Scotia

Wanda has been a reluctant consumer of mental health services since 1982 when she sought assistance for life issues arising out of childhood sexual abuse. Since that time, she has experienced bias and, unfortunately, revictimisation both inside and outside the mental health care system, as well as marginalisation and, more recently, unwarranted criminalisation as a result of her mental health history.

Nothwithstanding the challenges Ms. Cummings faced, now at the age of 48, she has spent her entire adult life advocating for the disadvantaged within any realm. She has always been a friend to the disillusioned, as well, offering hope, humour, and practical activism toward change, resolve, and restoring dignity. She is no stranger to community-oriented, grassroots movements and is a team player with avid listening skills, modest writing skills, and an earnest ability to speak up when called upon. For more than 25 years, she has worked as a graphic designer, illustrator, and teacher of some repute, servicing fortune 1000 companies, small businesses, non-profits, charities, and individuals with the same enthusiasm, creativity, and versatility.

Ms. Cummings was very excited to have recently learned about the MHCC Project as she believes both her intimate and bird's-eye views of those living in or around the mental health care system would offer a mutually beneficial exchange and, hopefully, another step toward

greatly needed, long overdue change.

British Columbia

Mark Stephens, Langely, British Columbia

Mark resides in Langley, BC and was diagnosed in 2001 with late onset "Schizo-Affective Bi-Polar Disorder" on his thirtieth Birthday while attending Kwantlen University College (Currently named Kwantlen Polytechnic University). Mark went on to obtain his Undergraduate Degree from the University of Victoria in Political Science in 2004.

Mark is a Public Speaker for the British Columbia Schizophrenia Society since 2006 sharing his personal story and his journey to recovery speaking to High Schools, Universities and Organizations. Further, Mark has been a Facilitator for the Canadian Mental Health Association, Delta Branch sharing the "Youth Net Program" to local High Schools.

Mark has received numerous awards for his personal achievements and has a great sense of civic duty offering his time to the local and larger community as a whole.

Trevor Fritz, Vancouver, British Columbia

I am 22-year old University of British Columbia student. In addition to my studies here, I've been working for the university for 4 years, doing research in the fields of psychiatry and psychopharmacology. When my depression first started, my English teacher encouraged me to write a research essay on a mental health-related topic to better understand what I was going through. I had no idea at the time, but my decision to write about the neurobiology of depression would change my life forever! Research quickly became my way of coping with all of the negative emotions and thoughts of suicide. My academic goals are to major in either biochemistry or biopsychology and go on to do the MD/PhD program at UBC and become a psychiatrist with a special interest in bipolar disorder research.

Other than research, some of my interests are mountain biking (Vancouver is great for that), photography and backpacking. One of my greatest achievements in life has been my completion of the infamous West Coast Trail, a 75km trail along the west coast of Vancouver Island. I took a lot of film production and photography courses in high school and they turned into hobbies after graduation. I have been in the mental health system for 7 years now, first with a child and adolescent psychiatrist and now with an adult psychiatrist. There have been psychiatrists I have liked, and some I really did not. I have also been hospitalized a total of 11 times, sometimes involuntarily.

I spent three years leading a young adult support group at the Mood Disorders Association of BC and now I am starting my own group at UBC. I have four volunteers, including one faculty member, and we are in the process of building a website and advertising. We are aiming to start this fall.

North West Territories

Arlene Hache, Yellowknife, Northwest Territories

Arlene Hache has 25 years experience providing front-line advocacy support to visible minority women and their families living in northern, remote communities. Arlene has been Executive Director of the Centre for Northern Families in Yellowknife, Northwest Territories Canada for more than 20 years. The Centre offers a broad range of services that support multi-stressed and marginalized families. She is well known across the North as an advocate for social change and is a founding partner in the development of therapeutic programs and in-home family support services designed to support families recovering from trauma related to colonization and ongoing violence. Arlene's passion stems from her own experiential recovery from trauma related to childhood abuse. Arlene was awarded the Order of Canada for her work in the North in 2009.

Quebec

Leah Daigneault, Montreal, Quebec

I was born in London, Ontario but I have been living in Quebec since the age of 9. I am therefore completely bilingual in reading, writing and speaking.

I am a trustworthy person, with a great passion and commitment to human rights of all forms; especially in the field of mental illness. I have a background in political science and law although I was unable to complete my degree due to having small children at that time; this has never stopped me from researching and reading up on the laws and changes in human rights policies within the government and the world. It has always been incredibly important to me to involve myself in committees and organizations where the rights of those living with a mental illness are the primary goal as they should be for every human. I was very proud to have been the project manager earlier this year in setting up a seminar or conference where the rights and freedoms of those living with a mental illness was the topic and the attendance was great in numbers from many fields including local government.

I have also personally experienced injustices as a person living with a mental illness. Two instances where looking for a job, one in the private sector and the other in a community organization specializing in mental illness, should not have proved to be very difficult, but it was.

On another note, having admitted myself once to the emergency room of the local hospital for suicide watch a few years ago, the stigma and disregard for my rights as an individual as well as someone with a mental illness was once again very apparent.

APPENDIX B: Consultation Group Terms of Reference

Background

The Mental Health Commission of Canada's Mental Health and the Law Advisory Committee was established to examine the rights of people living with mental health illness and the expression of these rights in law. The Evaluation Project Committee was formed by the Mental Health and the Law Advisory Committee to oversee the research and development of instruments to evaluate Canadian legislation and assess mental health policies and service standards as it relates to the rights of persons with mental illness. The Canadian Mental Health Association – Winnipeg, in partnership with the Public Interest Law Centre of Legal Aid Manitoba, will carry out the deliverables of the research in collaboration with the Evaluation Project Committee. The project deliverables are as follows:

1. Developing an instrument(s) to evaluate the extent to which human rights are addressed in legislation, policies, and service standards as it relates to persons experiencing mental illness;
2. Conducting a preliminary assessment of the degree to which the human rights of persons with mental illness are protected and advanced in existing federal and provincial legislation;
3. Drafting a set of core standards for mental health services that reflect human rights and social inclusion principles; and,
4. Developing a strategic plan that guides the dissemination of the instrument(s) developed to provincial and federal jurisdictions in Canada, including instruction on their use.

The instrument(s) developed will be piloted in three jurisdictions in Canada: 1) British Columbia, 2) Manitoba, and 3) Nova Scotia. The anticipated result in piloting the instrument(s) is that it will lead to recommendations for legislative and policy reform and service standards development that enhances and protects the human rights of persons with mental illness.

Purpose

A key component of the project is that a Consultation Group consisting of persons who have experienced mental health issues is formed for the purpose of providing guidance and feedback regarding the Evaluation Project deliverables. Drawing from personal experiences with mental illness and recovery, the members of the Consultation Group will provide their opinions, views, and suggestions for changes to the project deliverables in order that they most closely resemble and honour the experiences of persons who have mental illness; have received treatment for their illness; and who have experienced aspects of the recovery journey.

Membership

The Consultation Group will consist of a total of eight members: two individuals residing in each of the three pilot jurisdictions, one individual residing in a northern territory, and one individual residing in the province of Quebec. The intention is that the Group will bring a cross-section of different perspectives on the subject matter.

Chairperson

The Consultation Group will be chaired by Nicole Chammartin, Executive Director, Canadian Mental Health Association – Winnipeg.

Time Frame

The Consultation Group will be consulted regularly during the course of the Evaluation Project, which commences April 1, 2010 with an anticipated end date of September 30, 2011.

Frequency and Structure of Meetings

Meetings of the Consultation Group will take place in person as well as via teleconference. The meetings will be scheduled for the purpose of introducing the project, and for discussion and feedback regarding the key project deliverables (as outlined in the *Background* section).

Three (3) in-person meetings of the Consultation Group will take place during the course of the project. The tentative dates and associated purpose of the meetings are as follows:

July 2010 -	Introduction of Project; introduction of Project Research Team; sharing participant personal reflection assignments; finalizing Terms of Reference; and presentation of background material.
October 2010 -	Presentation of research findings and Consultation Group Assignment #2.
February 2011 -	Presentation of pilot process in jurisdictions and Consultation Group Assignment #3.

Meetings will be held via teleconference with the Consultation Group to discuss and receive feedback regarding key deliverables. The tentative dates and associated purpose of the meetings are as follows:

August 2010 -	Consultation Group members discuss progress regarding Assignment #2.
December 2010 -	Consultation Group members provide feedback on draft Evaluation Instrument(s) developed.

March 2011 -	Consultation Group members provide feedback on draft core service standards developed.
May 2011 -	Consultation Group members provide feedback on the assessment of existing legislation, policies and services standards based on piloting the Evaluation Instruments in three provinces.
June 2011 -	Consultation Group members provide feedback on the preliminary recommendations as they relate to legislative and policy reform, and core service standards development.

Incorporation of Feedback

The discussions of the Consultation Group will be documented for the purpose of ensuring that all feedback has been accurately interpreted and recorded. The members of the Consultation Group will receive the draft documentation following each meeting and will be provided with the opportunity to clarify and/or correct the meeting notes.

Confidentiality

The responses from Group members provided during the meetings will be confidential, meaning that members' names will not be tied to the recorded responses. Rather, the feedback on project deliverables will be reflected as feedback from the Group as a whole.

Group Interactions

The following are the expectations regarding the group interactions, as determined by the Consultation Group participants:

- The information that is shared in the meeting is kept confidential;
- Participants refrain from interrupting one another;
- Group interactions are based on respect and trust;
- Raise hand when you wish to enter the conversation;
- The discussion is facilitated so that the group stays focused, and time will be provided for open dialogue;
- Respect the project's mandate, and create "the parking lot" so that issues are not lost;
- Respect different views, beliefs and values;
- Use accessible language, recognizing that everyone's knowledge is not the same, e.g. acronyms, proper names, legislative codes, etc.;
- During teleconference meetings, indicate your name before speaking.

Model for Conflict Resolution

The process for conflict resolution is as follows:

- Talk to the person you have an issue with and work towards resolving the tension;
- If this is unsuccessful, ask Nicole to be the intermediary or another group member;
- Establish a parking lot for outstanding differences to be resolved after the project mandate is completed.

Decision-Making

The decisions made by the Consultation Group will be accomplished through consensus, and if consensus cannot be achieved, then a voting process is initiated (two-thirds majority). Depending on the issue, a voting process is not always necessary, and the difference in opinion can be documented.

The Consultation Group is considered to be an independent group that provides their opinions and input into the Project Research Team deliverables; namely the research findings, Evaluation Instrument(s) developed, and recommendations for legislation, policy and service standards. The Group's input is provided to the Project Research Team, who then in turn determines if it is incorporated into the deliverables produced for the Mental Health Commission of Canada (MHCC). If the position of the Consultation Group is not congruent with the position of the Project Research Team, then this is noted in the deliverable for MHCC, (i.e., report) and accompanied by a description of the differences of opinion.

Attendance and Assignments

Due to the short time frame of this project, and the importance of the work of the Consultation Group, it is important that all members are available for all meetings set, and that assignments are returned to the research team in a timely manner (e.g. by or prior to deadlines). It is understood that the Consultation Group participants may experience a relapse of their illness, or other personal circumstance, during the Group's tenure that could prevent participation in the short or long term. Due to the short time frame for this project, should this occur, the individual will not be released from the Group and will not be replaced, but rather will remain as a member of the Group, unless the individual requests otherwise.

Communication

The Project Research Team is committed to a transparent communication approach. As a result, the Consultation Group will be informed by the Project Research Team of the feedback regarding the project provided by the Mental Health Commission of Canada and the Evaluation Project Committee.

Review of Terms of Reference

The Terms of Reference will be reviewed at each meeting of the Consultation Group.

APPENDIX C: Stakeholder Focus Group Questions

A. Existing Mental Health Legislation, Policies and Standards

The Project Team, more specifically the Public Interest Law Centre of Legal Aid Manitoba, has collected some preliminary information regarding existing mental health legislation, regulations, polices and service standards in your province; however we would like to learn from you any information we may have missed.

1. What provincial mental health legislation currently exists in your province?
2. What other provincial legislation exists in your province that addresses vulnerable persons? e.g. Vulnerable Persons Act
3. What provincial mental health policies currently exist in your province?
4. What provincial mental health service standards currently exist in your province?
5. Are there other mental health policies and/or standards that exist that are different from the provincial policies such as mental health facility based policies and standards or Regional Health Authority based policies and standards? If so, how are they different?
6. Are there policies/standards that exist specifically as it relates to persons with mental illness in the justice system? If yes, what are these policies and standards?

B. Monitoring Bodies/Organizations

This set of questions, and the subsequent responses, is meant to inform the Project Team of how the rights of mental health service users are protected. In other words, the organizations and processes in existence within the province to ensure the provisions within the legislation, regulations, policies and service standards are met. Again, the Project Team has collected some preliminary information; however we want to ensure its accuracy.

1. What bodies/organizations exist in your province to hear complaints from mental health service users? e.g. Ombudsman, Human Rights Commission
2. Does your province have a Mental Health Review Board or Tribunal? If yes, what are its responsibilities?
3. Are there organizations in your province that are responsible for monitoring mental health services? If yes, what are they, how are they funded, and how are they governed? What process is used to monitor mental health services and how are the findings reported?

C. Realization of Human Rights

Below is a list of some of the key rights pertaining to persons experiencing a mental illness, as outlined in the Convention on the Rights of Persons with Disabilities. For each right, please indicate if the realization of this right for persons with a mental illness is a challenge in your province, and if so, indicate why this is the case.

1. Access to justice
    - This right encompasses two elements – (1) basic rights to ensure access to justice: (2) ensuring that persons with disabilities are able to access justice on an equal basis with others.
    - This right is relevant in the context of persons living with a mental illness primarily for:
        - the process that is in place if a person is unable to make decisions and lacks capacity due to mental illness, i.e. appointment of personal representative;
        - the process that is in place regarding voluntary and involuntary admission to mental health facility or treatment decisions;
        - the process that is in place regarding complaints if rights have been violated.
2. Liberty and security of the person
    - Basically this right means a person cannot arbitrarily or unlawfully be deprived of their liberty or security of the person. That means the right is not absolute and there are circumstances where deprivation of liberty or security of the person is justified.
    - Typically "liberty" means physical liberty, i.e. prison, mental health facility.
    - However, the rights to liberty and security the person are much broader than that. They include the right to make decisions that are fundamental to a person's life and identity; the right to make decisions about one's own body, i.e. the right to refuse medical treatment; and the right to be free from state-imposed psychological stress.
3. Freedom from torture or cruel, inhuman or degrading treatment of punishment
    - In the context of the project, this right relates primarily to the treatment of persons with mental illness in mental health facilities. It is all about what is considered to be humane treatment of persons with mental illness.
    - Includes items such as:
        - Free and informed consent to treatment without threats or inducement and only after full disclosure of understandable information;
        - Right to choose to discontinue treatment;
        - Treatment plans if the person lacks capacity to consent;
        - Physical restraint or seclusion;
        - "Treatment" such as sterilization, medical or surgical procedures, psycho surgery or other intrusive/irreversible treatments, clinical trials, experimental treatment;
        - Conditions of the mental health facility;
        - Conduct of staff;
        - Education/training of law enforcement, medical personnel and anyone else involved in the mental health system.
4. Living independently and being included in the community (i.e. participation and social inclusion)
    - This right is about persons with disabilities being able to live in their own community

on an equal basis as others and having equal choices regarding life in their own community.

- The needs of every individual are of equal importance and resources must be used so every individual has an equal opportunity to participate in community life. The term "community" includes education, housing, working, training, health care, social integration, cultural activities and leisure.
- This right includes:
  - the right to choose a place of residence and where and with whom to live and not be obligated to live in a particular living arrangement;
  - accessing in-home, residential and other community support services, including personal assistance necessary to support living in the community to prevent isolation or segregation;
  - community services and facilities that are available for the general population must be provided on an equal basis to persons with disabilities and these services and facilities must be responsive to their needs;
  - making the physical environment accessible;
  - providing accessible information and communication technologies;
  - the right to return to one's own community as soon as possible if a person has to
  - leave, i.e. for treatment;
  - culturally appropriate treatment and services.

5. Access to the highest attainable standard of physical and mental health treatment and services
   - Everyone has the right to the highest attainable standard of physical and mental health.
   - This right includes:
     - early detection and appropriate treatment;
     - women and men must have equal access to health care;
     - persons with disabilities are entitled to the same range, quality and standard of free or affordable health care as that provided to others;
     - persons with disabilities have the right to health care needed as a result of their specific disability;
     - health care services should be provided as close as possible to one's own community, including in rural areas.

D. Human Rights Environment

This next set of questions attempts to illicit information regarding the province's current outlook on human rights as it relates to persons with mental illness as a means of learning the province's receptivity to using a tool to measure the extent to which human rights is embedded in law and policy.

1. What is the status of human rights and mental illness in your province? In other words, what is the "tone" of the human rights/mental illness movement? Is the emphasis on

expanding the rights and freedoms of persons with mental illness, such as alternatives to the use of seclusion in mental health facilities or increasing availability of community-based prevention resources as a means of decreasing involuntary admissions to hospital, or is the emphasis on restricting the rights of persons with mental illness, such as adjusting the process to make it easier for persons to be involuntarily admitted to hospital?

2. Are there any recent events that have occurred in your province that might have had an impact on the public's will to expand or restrict the rights of persons with a mental illness? If so, what are they?
3. Are there any initiatives that have been or are being undertaken by government or non-government organizations in your province as it relates to human rights and mental illness? e.g. legislation reform, policy reform, development of mental health service standards?

APPENDIX D: Pilot Evaluation Team Terms of Reference

Background

The Mental Health Commission of Canada's Mental Health and the Law Advisory Committee was in part established to examine the rights of people living with a mental illness and the expression of these rights in law. The Evaluation Project Committee was formed by the Mental Health and the Law Advisory Committee to oversee the research and development of instruments to evaluate Canadian mental health legislation, policies and service standards as they relate to the rights of persons living with a mental illness. The Canadian Mental Health Association – Winnipeg, in partnership with the Public Interest Law Centre of Legal Aid Manitoba and Christine Ogaranko, Principal Researcher, were chosen by the Evaluation Project Committee to conduct the research and complete the following project deliverables:

1. Develop an instrument to evaluate the extent to which human rights are addressed in legislation, policies, and service standards as they relate to persons living with a mental illness;
2. Conduct a preliminary assessment of the degree to which the human rights of persons living with a mental illness are protected and advanced in existing mental health legislation;
3. Draft a set of core standards for mental health services that reflect human rights and social inclusion principles; and,
4. Develop a strategic plan that guides the dissemination of the instrument developed including instruction on its use.

The instrument developed will be piloted in three jurisdictions in Canada: 1) British Columbia, 2) Manitoba, and 3) Nova Scotia. The anticipated result in piloting the instrument is that it will lead to recommendations for legislative and policy reform and service standard development that enhance and protect the human rights of persons living with a mental illness.

A key component of the project is the establishment of a Consultation Group consisting of persons living with a mental illness to provide guidance and feedback regarding the project deliverables. In particular, and drawing from personal experiences with mental illness and recovery, the members of the Consultation Group have provided their opinions, views, and suggestions for the Draft Mental Health and Human Rights Evaluation Instrument.

Purpose

The purpose of the Pilot Evaluation Teams (PETs) is to implement the *Draft Mental Health and Human Rights Evaluation Instrument* within their respective province. The PETs will apply the instrument to their **provincial** mental health legislation, policies, and service standards and provide the responses to the evaluation questions electronically. Furthermore, the PETs will make recommendations to the Project Research Team regarding the functionality of the tool in this context.

Lead Organization/Chair

The PETs will be led by an organization within the pilot jurisdiction, in consultation with the Project Research Team. The lead organization within each jurisdiction will be chosen by the Project Research Team following a call for an expression of interest by organizations that they meet the following criteria:

- The organization has the internal resources and ability to meet timelines
- The organization has a provincial scope or mandate, and/or existing partnerships with provincial organizations
- The organization has a demonstrated history and interest in the area of human rights for persons living with a mental illness
- The organization has a proven record of working collaboratively with government and non government entities
- The organization has knowledge and familiarity with mental health legislation, policies and service standards

The responsibilities of the lead organization include:

- Identifying potential members of the PET, representative of the sectors outlined below
- Inviting the potential members of the PET to participate in the evaluation process
- Participating in training regarding the Draft Mental Health and Human Rights Instrument
- Hosting and chairing regularly scheduled meetings of the PET
- Ensuring that the Evaluation Instrument is completed and submitted to the Project Research Team by the designated due date
- Ensuring that the feedback regarding the Evaluation Instrument is provided to the Project Research Team by the designated due date
- Participating in periodic progress meetings (via teleconference) with the Project Research Team

Membership

The PETs consist of 10-12 members that each have experience and knowledge in one or more of the following areas: human rights, mental illness, law, mental health service delivery, legal advocacy, mental health service advocacy, mental health legislation, mental health policy, and/or mental health service standards. In addition, one local member of the Project's Consultation Group will be a member of the PET. The membership should reflect the cultural interests within the jurisdiction as well as a rural/urban representation. At a minimum, the membership should include:

- Relevant mental health non-government organizations such as the Canadian Mental Health Association (CMHA), Mood Disorders Association and Schizophrenia Society
- Legal Advocates

- Human Rights Commission
- Mental Health Branches of the Provincial Government
- Family members
- Psychiatry/Mental Health Service Providers (community and hospital)
- Persons with lived experience

The responsibilities of the PET members include:

- Attending scheduled meetings called by the Chair of the PET
- Completing the Evaluation Instrument by the due date
- Providing feedback regarding the Evaluation Instrument by the due date

Process

The Lead Organization Chairperson, will participate in a training session regarding the use of the *Draft Mental Health and Human Rights Evaluation Instrument*. Following the training session, an initial meeting of the PET will be convened to determine the meeting schedule. The meeting schedule will reflect a collaborative process in the completion of the Evaluation Instrument.

The instrument will be completed by the group as a whole; however, if there are evaluation questions that require additional information, a member of the PET whose area of expertise applies will be assigned the responsibility from the Chairperson to gather the necessary information and bring it back to the larger group. While completing the instrument, the PET should refer to the current provincial mental health legislation or series of legislation pertaining to persons living with a mental illness, provincial mental health policies and provincial service standards.

Time Frame

April 2011	- The Project Research Team identifies and appoints the Lead Organizations - The PET members are invited and appointed by the lead organizations
Late April, early May 2011	- The PETs receive training in utilization of the evaluation instrument
May and June 2011	- The PETs complete the Evaluation Instrument
June 30, 2011	- The PETs submit completed Evaluation Instruments to the Project Research Team
July 2011	- The PETs provide feedback on the evaluation tool and process

Frequency and Structure of PET Meetings

To be established by the Lead Organization of the Pilot Evaluation Teams.

APPENDIX E: Participant Evaluation Questionnaire

INSTRUCTIONS:

The aim of this questionnaire is to determine the effectiveness of the *Mental Health and Human Rights Evaluation Instrument* in soliciting the responses necessary to evaluate existing mental health law, policy and service standards in relation to human rights and related principles.

Please answer the following questions by placing an X in the box provided. There is space at the end of the questionnaire to provide specific comments.

The questionnaire can be completed either electronically or by hand. If completed electronically, please send the completed questionnaire as an attachment to Christine Ogaranko at cogarank@mts.net. If completing the questionnaire by hand, you can either scan the document and send it to the same e-mail address above, or fax it to the attention of Beverly Froese, Public Interest Law Centre at (204) 985-8544.

The completed questionnaires and the responses provided will be kept confidential and no identifying information will be used in the analysis of the information provided or in the reporting of the results.

Name of Province: _____

A. Sections in the Evaluation Tool

i. The **glossary** helped to further our understanding of the concepts used in the Evaluation Instrument.

☐ Strongly Disagree ☐ Disagree ☐ Neither Agree nor Disagree ☐ Agree ☐ Strongly Agree

ii. The **instructions** at the beginning of the sections on principles and rights were clear and easy to understand.

☐ Strongly Disagree ☐ Disagree ☐ Neither Agree nor Disagree ☐ Agree ☐ Strongly Agree

iii. The **definitions** of the principles and human rights located at the beginning of each sub-section helped to clarify the meaning of the principle or right.

☐ Strongly Disagree ☐ Disagree ☐ Neither Agree nor Disagree ☐ Agree ☐ Strongly Agree

iv. The **pertinent issues** outlined in the instrument of how the principle or right affected persons living with a mental illness helped to identify the important areas to take into consideration when formulating a response.

☐ Strongly Disagree ☐ Disagree ☐ Neither Agree nor Disagree ☐ Agree ☐ Strongly Agree

v. The **explanation of how the principle or right is achieved** increased my understanding of what to look for when assessing mental health legislation, policy and standards.

☐ Strongly Disagree ☐ Disagree ☐ Neither Agree nor Disagree ☐ Agree ☐ Strongly Agree

B. Evaluation Questions

i. The evaluation questions were **clearly stated and easily understood**.

☐ Strongly Disagree ☐ Disagree ☐ Neither Agree nor Disagree ☐ Agree ☐ Strongly Agree

ii. There was a **clear link** between the evaluation question and the principle or right.

☐ Strongly Disagree ☐ Disagree ☐ Neither Agree nor Disagree ☐ Agree ☐ Strongly Agree

iii. The evaluation questions **helped to determine if the principle or right was addressed** in the mental health legislation, policy, or standard being reviewed.

☐ Strongly Disagree ☐ Disagree ☐ Neither Agree nor Disagree ☐ Agree ☐ Strongly Agree

C. Evaluation Responses

i. The **rating scale** of 'addressed in full, partially addressed, and not at all addressed' was an **adequate measure** of the extent to which the principles and rights were included in the mental health legislation, policy, or standard being reviewed.

☐ Strongly Disagree ☐ Disagree ☐ Neither Agree nor Disagree ☐ Agree ☐ Strongly Agree

ii. The **categories for explaining the response**, e.g. 'elements addressed in the legislation, elements not addressed in the legislation', **enabled** me to provide a thorough response.

☐ Strongly Disagree ☐ Disagree ☐ Neither Agree nor Disagree ☐ Agree ☐ Strongly Agree

D. Structure of Evaluation Instrument

i. The Evaluation Instrument was **organized in a way that was logical and made sense**.

☐ Strongly Disagree ☐ Disagree ☐ Neither Agree nor Disagree ☐ Agree ☐ Strongly Agree

ii. The **length** of the Evaluation Instrument was **adequate** to conduct a comprehensive evaluation of mental health legislation, policy and service standards.

☐ Strongly Disagree ☐ Disagree ☐ Neither Agree nor Disagree ☐ Agree ☐ Strongly Agree

E. Evaluation Process

i. The **process** our group chose to complete the Evaluation Instrument **contributed to a thorough evaluation** of mental health legislation, policy and standards.

☐ Strongly Disagree ☐ Disagree ☐ Neither Agree nor Disagree ☐ Agree ☐ Strongly Agree

ii. The **process** our group followed in completing the Evaluation Instrument **facilitated group discussion that was helpful** in formulating the responses.

☐ Strongly Disagree ☐ Disagree ☐ Neither Agree nor Disagree ☐ Agree ☐ Strongly Agree

F. Knowledge of Mental Health and Human Rights

i. **After participating** in this process to evaluate mental health legislation, policy and standards, **my knowledge of mental health and human rights has increased**.

☐ Strongly Disagree ☐ Disagree ☐ Neither Agree nor Disagree ☐ Agree ☐ Strongly Agree

ii. **After completing** the Evaluation Instrument, I have a **good understanding** of what principles and human rights are sufficiently addressed in my province's mental health legislation, policies and standards, and what areas require improvement.

☐ Strongly Disagree ☐ Disagree ☐ Neither Agree nor Disagree ☐ Agree ☐ Strongly Agree

Please provide any comments you may have pertaining to the previous statements or any other issues you would like the researchers to be aware of related to the Mental Health and Human Rights Evaluation Instrument.

APPENDIX F: Summary of Evaluation Results by Province

The tables on the following pages contain the scores for each question answered in the Evaluation Instrument and there is a set of two tables for each participating pilot province; one table for the results of the human rights principles section and one table for the human rights section in the instrument.

It is important to note that since piloting the Evaluation Instrument in Nova Scotia, Manitoba and British Columbia the Evaluation Instrument has been revised based on the feedback received following the pilot process. As a result, the question numbers in the tables no longer correspond to the actual Evaluation instrument.

Due to the reason that this was a piloting exercise, it is not possible to draw any definite conclusions about the status of mental health legislation, policies and standards in each pilot province nor is it prudent to conduct a comparison of the results across the provinces. Rather, the purpose of summarizing the evaluation results is simply to show in a broad sense the extent to which respective legislation, policies and standards address human rights in the pilot sites. It is anticipated that the use of the revised version of the Evaluation Instrument along with a revised evaluation process as described in this report will produce the results needed to draw more definitive conclusions for the purpose of provincial planning and national monitoring of the CRPD.

1. a. Nova Scotia - Principles

Note: As Nova Scotia does not have provincial mental health policies, the evaluation questions pertaining to policies have been noted as 'not applicable'.

Principle Statements	Addressed in Full	Partially Addressed	Not at all addressed
1. Respect for inherent dignity, individual autonomy and independence, and the freedom to make one's own choices			
PR1		✓	
PR2	Not applicable – no mental health policies		
PR3		✓	
2. Non-discrimination and equality of opportunity			
PR4			✓
PR5	Not applicable		
PR6			✓
3. Full and effective participation and inclusion in society			
PR7			✓
PR8		✓	
PR9	Not applicable		
PR10			✓
4. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity			
PR11			✓
PR12	Not applicable		
PR13		✓	
5. Accessibility			
PR14		✓	
PR15	Not applicable		
PR16		✓	
6. Equality between men and women			
PR17			✓
PR18	Not applicable		
PR19			✓
7. Respect for evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities			
PR20			✓
8. Respect for cultural diversity, including language, values, beliefs and traditions			
PR21	Not applicable		
9. Transparency and accountability			
PR22			✓
PR23	Not applicable		
PR24	Not applicable		
PR25			✓
Total	**0/16**	**6/16**	**10/16**

1. b. Nova Scotia - Rights

Note: As Nova Scotia does not have provincial mental health policies, the evaluation questions pertaining to policies have been noted as 'not applicable' and deducted from the total number of questions. The questions not answered are noted at 'missing'.

Right Statements	Addressed in Full	Partially Addressed	Not at all Addressed
1. Right to life			
R1			✓
R2	Not applicable		
2. Situations of risk and humanitarian emergencies			
R3	Not applicable		
3. Equal recognition before the law			
R4			✓
R5		✓	
R6		✓	
R7		✓	
R8			✓
R9			✓
R10		✓	
R11			✓
R12	Not applicable		
R13	Not applicable		
R14			✓
R15			✓
4. Access to justice			
R16		✓	
R17		✓	
R18		✓	
R19		✓	
R20		✓	
R21			✓
R22		✓	
R23	Not applicable		
R24	Not applicable		
R25	Not applicable		
R26	Not applicable		
R27	Not applicable		
R28			✓
R29			✓
R30			✓
5. Liberty and security of the person			
R31			✓
R32		✓	
R33		✓	
R34		✓	
R35		✓	
Sub-total	**0/26**	**14/26**	**12/26**
Right Statements	**Addressed in Full**	**Partially Addressed**	**Not at all Addressed**

Statements	in Full	Addressed	Addressed
R36		✓	
R37	✓		
R38		✓	
R39		✓	
R40	✓		
R41		✓	
R42			✓
R43	Not applicable		
R44	Not applicable		
R45	Not applicable		
R46			✓
R47			✓
R48			✓
R49			✓
6. Freedom from torture or cruel, inhuman or degrading treatment or punishment			
R50	Missing		
R51	Missing		
R52			✓
R53			✓
R54			✓
R55			✓
R56			✓
R57			✓
R58	Not applicable		
R59	Not applicable		
R60	Not applicable		
R61	Missing		
R62	Missing		
R63	Missing		
7. Freedom from exploitation, violence and abuse			
R64	Missing		
R65	Missing		
R66	Missing		
R67	Missing		
R68	Not applicable		
R69	Not applicable		
R70	Not applicable		
R71	Not applicable		
R72	Not applicable		
R73	Missing		
Sub-total	**2/27**	**4/27**	**11/27**
Right Statements	**Addressed in Full**	**Partially Addressed**	**Not at all Addressed**

8. Living independently and being included in the community			
R74		✓	
R75	Not applicable		
R76		✓	
9. Personal mobility			
R77	Missing		
R78	Not applicable		
R79	Missing		
10. Freedom of expression and opinion, and access to information			
R80	Missing		
R81	Not applicable		
R82	Not applicable		
R83	Not applicable		
R84	Not applicable		
11. Respect for privacy			
R85	Missing		
R86	Missing		
R87	Not applicable		
R88	Not applicable		
R89	Missing		
R90	Missing		
R91	Missing		
R92	Missing		
12. Respect for home and family			
R93	Missing		
R94	Not applicable		
R95	Not applicable		
R96	Missing		
13. Education			
R97	Not applicable		
R98	Missing		
14. Health			
R99	Missing		
R100	Not applicable		
R101	Not applicable		
R102	Not applicable		
R103	Not applicable		
R104	Not applicable		
R105	Not applicable		
R106	Not applicable		
R107	Not applicable		
R108	Not applicable		
R109	Not applicable		
R110	Not applicable		
R111	Not applicable		
R112	Not applicable		
Sub-total	**0/15**	**2/15**	**0/15**

Right Statements	**Addressed in Full**	**Partially Addressed**	**Not at all Addressed**
R113	Not applicable		
R114	Missing		
R115	Missing		
R116	Missing		
R117	Missing		
R118	Missing		
R119	Missing		
15. Habilitation and Rehabilitation			
R120			✓
R121	Not applicable		
R122		✓	
16. Work and employment			
R123	Not applicable		
R124			✓
17. Adequate standard of living and social protection			
R125	Not applicable		
18. Participation in political and public life			
R126	Not applicable		
R127	Not applicable		
R128	Not applicable		
19. Participation in cultural life, recreation, leisure and sport			
R129	Not applicable		
Sub-total	**0/9**	**1/9**	**2/9**
Total	**2/77**	**21/77**	**25/77**

2. a. Manitoba - Principles

Note: As Manitoba does not have provincial mental health standards, the evaluation questions pertaining to standards have been noted as 'not applicable', and deducted from the total number of evaluation questions.

Principle Statements	Addressed in Full	Partially Addressed	Not at All Addressed
1. Respect for inherent dignity, individual autonomy and independence, and the freedom to make one's own choices			
PR1		✓	
PR2		✓	
PR3	Not applicable		
2. Non-discrimination and equality of opportunity			
PR4		✓	
PR5		✓	
PR6	Not applicable		
3. Full and effective participation and inclusion in society			
PR7			✓
PR8		✓	
PR9			✓
PR10	**Not applicable**		
4. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity			
PR11		✓	
PR12		✓	
PR13	**Not applicable**		
5. Accessibility			
PR14		✓	
PR15		✓	
PR16	**Not applicable**		
6. Equality between men and women			
PR17			✓
PR18			✓
PR19	**Not applicable**		
7. Respect for evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities			
PR20			✓
8. Respect for cultural diversity, including language, values, beliefs and traditions			
PR21		✓	
9. Transparency and accountability			
PR22		✓	
PR23		✓	
PR24			✓
PR25	**Not applicable**		
Total	**0/18**	**12/18**	**6/18**

2. b. Manitoba - Rights

Note: As Manitoba does not have provincial mental health standards, the evaluation questions pertaining to standards have been noted as 'not applicable', and deducted from the total number of evaluation questions. The questions not answered are noted as 'missing'.

Right Statements	Addressed in Full	Partially Addressed	Not at All Addressed
1. Right to life			
R1		✓	
R2		✓	
2. Situations of risk and humanitarian emergencies			
R3			✓
3. Equal recognition before the law			
R4		✓	
R5		✓	
R6	✓		
R7	✓		
R8			✓
R9		✓	
R10		✓	
R11	✓		
R12			✓
R13			✓
R14	Not applicable		
R15	Not applicable		
4. Access to justice			
R16		✓	
R17			✓
R18		✓	
R19	✓		
R20	✓		
R21		✓	
R22		✓	
R23			✓
R24			✓
R25			✓
R26			✓
R27			✓
R28	Not applicable		
R29	Not applicable		
R30	Not applicable		
5. Liberty and security of the person			
R31		✓	
R32			✓
R33		✓	
R34	✓		
R35		✓	

Sub-total	6/30	13/30	11/30
Right Statements	**Addressed in Full**	**Partially Addressed**	**Not at All Addressed**
R36	✓		
R37	✓		
R38	✓		
R39	✓		
R40	✓		
R41			✓
R42			✓
R43			✓
R44			✓
R45			✓
R46	Not applicable		
R47	Not applicable		
R48	Not applicable		
R49	Not applicable		
6. Freedom from torture or cruel, inhuman or degrading treatment or punishment			
R50	Missing		
R51	Missing		
R52	Missing		
R53	Missing		
R54	Missing		
R55	Missing		
R56	Missing		
R57	Missing		
R58	Missing		
R59	Missing		
R60	Missing		
R61	Not applicable		
R62	Not applicable		
R63	Not applicable		
7. Freedom from exploitation, violence and abuse			
R64	Missing		
R65	Missing		
R66	Missing		
R67	Missing		
R68	Missing		
R69	Missing		
R70	Missing		

R71	Missing		
R72	Missing		
R73	Not applicable		
Sub-total	**5/30**	**0/30**	**5/30**
Right Statements	**Addressed in Full**	**Partially Addressed**	**Not at All Addressed**
8. Living independently and being included in the community			
R74			✓
R75			✓
R76	Not applicable		
9. Personal mobility			
R77			✓
R78			✓
R79	Not applicable		
10. Freedom of expression and opinion, and access to information			
R80		✓	
R81			✓
R82			✓
R83			✓
R84			✓
11. Respect for privacy			
R85	✓		
R86	✓		
R87			✓
R88			✓
R89	Not applicable		
R90	Not applicable		
R91	Not applicable		
R92	Not applicable		
12. Respect for home and family			
R93			✓
R94		✓	
R95		✓	
R96	Not applicable		
13. Education			
R97			✓
R98	Not applicable		
14. Health			
R99			✓
R100		✓	
R101	✓		
R102		✓	
R103		✓	
R104		✓	
R105			✓
R106		✓	
R107		✓	
R108			✓
R109			✓
R110			✓
R111			✓
R112		✓	
Sub-total	**3/31**	**10/31**	**18/31**
Right Statements	**Addressed in Full**	**Partially Addressed**	**Not at All Addressed**
R113		✓	
R114	Not applicable		
R115	Not applicable		
R116	Not applicable		
R117	Not applicable		
R118	Not applicable		
R119	Not applicable		
15. Habilitation and Rehabilitation			
R120		✓	
R121		✓	
R122	Not applicable		
16. Work and employment			
R123			✓
R124	Not applicable		
17. Adequate standard of living and social protection			
R125			✓
18. Participation in political and public life			
R126		✓	
R127			✓
R128		✓	
19. Participation in cultural life, recreation, leisure and sport			
R129			✓
Sub-total	**0/9**	**5/9**	**4/9**
Total	**14/100**	**28/100**	**38/100**

3. a. British Columbia - Principles

Note: Scores for the evaluation of the Early Psychosis Intervention Standards and Guidelines were not available and are noted as 'missing' for all questions pertaining to standards.

Principle Statements	Addressed in Full	Partially Addressed	Not at All Addressed
1. Respect for inherent dignity, individual autonomy and independence, and the freedom to make one's own choices			
PR1		✓	
PR2		✓	
PR3	Missing		
2. Non-discrimination and equality of opportunity			
PR4		✓	
PR5		✓	
PR6	Missing		
3. Full and effective participation and inclusion in society			
PR7		✓	
PR8	Missing		
PR9		✓	
PR10	Missing		
4. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity			
PR11		✓	
PR12		✓	
PR13	Missing		
5. Accessibility			
PR14		✓	
PR15		✓	
PR16	Missing		
6. Equality between men and women			
PR17		✓	
PR18		✓	
PR19	Missing		
7. Respect for evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities			
PR20	✓		
8. Respect for cultural diversity, including language, values, beliefs and traditions			
PR21		✓	
9. Transparency and accountability			
PR22		✓	
PR23		✓	

PR24			✓
PR25	Missing		
Total	**1/25**	**15/25**	**1/25**

3. b. British Columbia - Rights

Note: The questions not answered are noted as 'missing'.

Right Statements	Addressed in Full	Partially Addressed	Not at All Addressed
1. Right to life			
R1			✓
R2			✓
2. Situations of risk and humanitarian emergencies			
R3		✓	
3. Equal recognition before the law			
R4		✓	
R5		✓	
R6			✓
R7			✓
R8		✓	
R9		✓	
R10		✓	
R11			✓
R12		✓	
R13			✓
R14	Missing		
R15	Missing		
4. Access to justice			
R16	✓		
R17			✓
R18		✓	
R19		✓	
R20		✓	
R21		✓	
R22		✓	
R23			✓
R24			✓
R25		✓	
R26			✓
R27			✓
R28	Missing		
R29	Missing		
R30	Missing		
5. Liberty and security of the person			
R31	Missing		
R32	Missing		
R33	Missing		
R34	Missing		
R35	Missing		
Sub-total	**1/35**	**13/35**	**11/35**
Right Statements	**Addressed in Full**	**Partially Addressed**	**Not at All Addressed**
R36	Missing		
R37	Missing		
R38	Missing		
R39	Missing		
R40	Missing		
R41	Missing		
R42	Missing		
R43			✓
R44			✓
R45			✓
R46	Missing		
R47	Missing		
R48	Missing		
R49	Missing		
6. Freedom from torture or cruel, inhuman or degrading treatment or punishment			
R50			✓
R51			✓
R52			✓
R53			✓
R54		✓	
R55		✓	
R56			✓
R57			✓
R58			✓
R59			✓
R60			✓
R61	Missing		
R62	Missing		
R63	Missing		
7. Freedom from exploitation, violence and abuse			
R64			✓
R65		✓	
R66			✓
R67			✓
R68			✓
R69			✓
R70		✓	
R71		✓	
R72			✓
R73	Missing		
Sub-total	**0/38**	**5/38**	**18/38**
Right Statements	**Addressed in Full**	**Partially Addressed**	**Not at All Addressed**
8. Living independently and being included in the community			
R74			✓
R75		✓	

R76	Missing		
9. Personal mobility			
R77	Missing		
R78		✓	
R79	Missing		
10. Freedom of expression and opinion, and access to information			
R80		✓	
R81		✓	
R82		✓	
R83			✓
R84		✓	
11. Respect for privacy			
R85		✓	
R86			✓
R87			✓
R88			✓
R89	Missing		
R90	Missing		
R91	Missing		
R92	Missing		
12. Respect for home and family			
R93			✓
R94		✓	
R95	✓		
R96	Missing		
13. Education			
R97		✓	
R98	Missing		
14. Health			
R99		✓	
R100	✓		
R101		✓	
R102	✓		
R103		✓	
R104	✓		
R105		✓	
R106		✓	
R107		✓	
R108			✓
R109		✓	
R110			✓
R111			✓
R112		✓	
Sub-total	**4/39**	**17/39**	**9/39**
Right Statements	**Addressed in Full**	**Partially Addressed**	**Not at All Addressed**
R113		✓	
R114	Missing		
R115	Missing		
R116	Missing		
R117	Missing		
R118	Missing		
R119	Missing		
15. Habilitation and Rehabilitation			
R120			✓
R121		✓	
R122	Missing		
16. Work and employment			
R123		✓	
R124	Missing		
17. Adequate standard of living and social protection			
R125		✓	
18. Participation in political and public life			
R126		✓	
R127		✓	
R128		✓	
19. Participation in cultural life, recreation, leisure and sport			
R129		✓	
Sub-total	**0/17**	**8/17**	**1/17**
Total	**5/129**	**43/129**	**39/129**